SERFF Tracking Number:	*MEAM-125712760*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*39444*
Company Tracking Number:	*SPL2-336-AR-0708*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SPL2-336-AR-0708*		
Project Name/Number:	*NAIC Model Filing/*		

Filing at a Glance

Company: MedAmerica Insurance Company

Product Name: SPL2-336-AR-0708	SERFF Tr Num: MEAM-125712760	State: ArkansasLH
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed	State Tr Num: 39444
Sub-TOI: LTC03I.001 Qualified	Co Tr Num: SPL2-336-AR-0708	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Marie Bennett, Harris Shearer
	Authors: Mary Lou Lawson, Lorie Heimbuck	Disposition Date: 08/13/2008
	Date Submitted: 06/27/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: NAIC Model Filing	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/13/2008	
State Status Changed: 08/13/2008	Deemer Date:

Corresponding Filing Tracking Number: SPL2-336-AR-0708

Filing Description:

In response to Arkansas' mandate implementing the 2006 version of the NAIC Long Term Care Insurance Model Regulation, the enclosed form filing is submitted for your review. We are also requesting approval to use this policy with the partnership program. See attached cover letter for complete description.

Company and Contact

SERFF Tracking Number:	*MEAM-125712760*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*39444*
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Product Name:	*SPL2-336-AR-0708*		
Project Name/Number:	*NAIC Model Filing/*		

Filing Contact Information

Mary Lou Lawson, LTC Compliance Analyst
165 Court Street
Rochester , NY 14647

mary.lou.lawson@medamericaltc.com
(585) 327-6522 [Phone]
(585) 238-3642[FAX]

Filing Company Information

MedAmerica Insurance Company
165 Court Street

Rochester, NY 14647
(585) 327-6522 ext. [Phone]

CoCode: 69515
Group Code:

Group Name:
FEIN Number: 34-0977231

State of Domicile: Pennsylvania
Company Type: Long Term Care Insurance
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
MedAmerica Insurance Company	$50.00	06/27/2008	21122410

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
	$0.00	

SERFF Tracking Number:	*MEAM-125712760*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*39444*
Company Tracking Number:	*SPL2-336-AR-0708*		
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Product Name:	*SPL2-336-AR-0708*		
Project Name/Number:	*NAIC Model Filing/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	08/13/2008	08/13/2008

SERFF Tracking Number:	*MEAM-125712760*	*State:*	*Arkansas*
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Product Name:	*SPL2-336-AR-0708*		
Project Name/Number:	*NAIC Model Filing/*		

Disposition

Disposition Date: 08/13/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MEAM-125712760*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*39444*
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Project Name/Number:	*NAIC Model Filing/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		No
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	Issuer Certification Form		Yes
Supporting Document	Forms List		Yes
Supporting Document	Red-Lined Pages		Yes
Form	POLICY		Yes
Form	Suitability		Yes

SERFF Tracking Number:	*MEAM-125712760*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*39444*
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Project Name/Number:	*NAIC Model Filing/*		

Form Schedule

Lead Form Number: SPL2-336-AR-0708

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	SPL2-336-AR-0708	Policy/Contract/Fraternal Certificate	POLICY	Revised	Replaced Form #: SPL2-336-AR Previous Filing #:		SPL2-336-AR-0708.pdf
	202 rev	Other	Suitability	Revised	Replaced Form #: 202 Previous Filing #:		202 rev .pdf

MEDAmerica
INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

Administrative Offices:
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

Simplicity^{ii}SM

Thank You for selecting MedAmerica Insurance Company as Your long term care insurer. We are pleased to provide You with this Policy. Your coverage, if the first premium is paid, as stated herein, begins at 12:01 a.m. Standard time at Your home on the Effective Date of this Policy. It ends on 12:01 a.m. Standard time at Your home on the termination date of this Policy.

This Policy is intended to be a federally tax-qualified long term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Us.

DISCLAIMER: THIS POLICY IS NOT DISABILITY INSURANCE OR ANY OTHER TYPE OF INCOME REPLACEMENT COVERAGE. Benefits under this Policy do not replace income or provide payment in the event of illness or accident resulting in disabilities not meeting the definition of Benefit Eligibility as contained herein.

SUBROGATION: If You become eligible for Benefits under this Policy as the result of injury or illness for which another party may be responsible, and We pay You Benefits as the result of that injury or illness, We reserve the right to pursue recovery from such third party, whether by judgment, settlement or otherwise, to the extent of the total amount of Benefits paid to You under this Policy, less reasonable and necessary expenditures, including attorneys' fees, incurred in effecting such recovery. Our right to proceed against the third party is independent of any right of action You may have.

Failure To Cooperate: If You fail to cooperate with Us in proceeding against the party responsible for Your illness or injury to recover the Benefits We have paid, We will be entitled to be reimbursed for said Benefits from a settlement or judgement You receive from the responsible party.

GUARANTEED RENEWABLE/PREMIUM INCREASES: This Policy will continue for Your lifetime as long as You do not exhaust the Cash Benefit Account and You pay the premiums within the allowable time. We cannot change the provisions of this Policy without Your consent. We can change Your premium with 45 days written notice, but only if We change the premiums for all similar Policies issued in Your state on this Policy form. You cannot be singled out for any increase because of a change in Your age or health. NOTE: With the exception of the statement that We cannot change the provisions of this Policy without Your consent, the above paragraph does not apply to Policies on which premiums are no longer payable.

IMPORTANT 30-DAY REVIEW: If You feel this Policy does not meet Your needs, You may return it to Your producer or Us within 30 days. If You do so: (1) We will return the premium You paid; and (2) We will not provide any Benefits under this Policy.

CAUTION: The issuance of this long term care Policy is based upon Your responses to the questions on Your application. A copy of Your application is enclosed. If Your answers are incorrect or untrue, We have the right to deny Benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at the above mailing address.

You may reach the Arkansas Insurance Department at the following address: Arkansas Insurance Department, Consumer Services Division, 1200 West Third Street, Little Rock, AR 72201-1904 or call [1-501-371-2640 or 1-800-852-5494].

This Policy is signed on Our behalf by Our President.

[ ]
[Christopher D. Perna]
[President]

TABLE OF CONTENTS

SCHEDULE OF POLICY BENEFITS

Simplicity[ii]

POLICY NUMBER: SPL2-336-AR-0708

BILLING ACCOUNT #:

ORIGINAL POLICY EFFECTIVE DATE: MM/DD/YY

[POLICY CHANGE EFFECTIVE DATE: MM/DD/YY]

POLICYHOLDER ISSUE AGE: [(18-85)]

PAYMENT MODE:

INSURED NAME: XXXXXXXXXX X XXXXXXXXXXXXXX XXX

ADDRESS: Line 1

Line 2

City, State, ZIP Code

BASE BENEFITS AND PREMIUM INFORMATION

ELIMINATION PERIOD:	[30]; [60]; [90]; [180] Days	
CASH BENEFIT ACCOUNT:	[$9,999,999]	
COMMUNITY MONTHLY CASH BENEFIT:	[$99,999] Per Month	
FACILITY MONTHLY CASH BENEFIT:	[$99,999] Per Month	
BASIC BENEFITS MODAL PREMIUM: [Comprehensive Coverage]; [Community Only]; [Facility Only]		[$ 99,999.99]
PREMIUM PAYMENT OPTION: **[X Lifetime:** Premiums are payable as long as Your Policy is in force.] **[X 10 Pay:** Premiums are payable until the 10th Policy Anniversary Date.] **[X Paid Up At Age 65:** Premiums are payable until the first Policy Anniversary Date on or after Your 65th birthday.]		
OPTIONAL RIDERS MODAL PREMIUM:		[$ 99,999.99]
[No Inflation, Benefits Remain Level]; [Simple Benefit Increase Rider]; [5% Compound Inflation Rider – 2X Maximum Rider]; [[3%], [5%] Compound Inflation– No Maximum Rider]	[$ 9,999.99]	
[Survivor Benefit Rider]	[$ 9,999.99]	
[Shared Waiver Rider]	[$ 9,999.99]	
[Shared Care Rider]	[$ 9,999.99]	
[Shortened Benefit Period Rider]	[$ 9,999.99]	
[Return of Premium Rider]	[$ 9,999.99]	
[Full Return of Premium Rider]	[$ 9,999.99]	
[Restoration of Benefits Rider]	[$ 9,999.99]	
Discounts Applied: [Affiliation]; [Employer Program]		**[$ 99,999.99]**
Total Modal Premium Including Optional Riders and Discounts		**[$ 99,999.99]**
Total Annualized Premium Including Optional Riders and Discounts		**[$ 99,999.99]**

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL)

Each of the following is an Activity of Daily Living:

Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.

Toileting: This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: This means the ability to move into or out of a bed, chair, or wheelchair.

ASSESSMENT

An Assessment is an evaluation of Your ability to perform Activities of Daily Living and Your cognitive condition to certify whether You are Chronically Ill. A Licensed Health Care Practitioner using recognized and accepted, objective standards of measurement must perform the Assessment. The Assessment must be made at the time You wish to establish Benefit Eligibility.

BENEFICIARY

A Beneficiary is a person or entity named by You to receive any premiums that may be due in the event of Your death.

BENEFITS

Benefits are the payments this Policy pays. They are described in the Schedule of Policy Benefits and any Riders attached to this Policy.

BENEFIT ELIGIBLE or BENEFIT ELIGIBILITY

This means You will receive Benefits. To be Benefit Eligible or achieve Benefit Eligibility under this Policy all of the following conditions must be met.

1. We have verified You are Chronically Ill;
2. You have a Plan of Care; and
3. Your Elimination Period has been met. (Does not apply to Benefits that do not require meeting the Elimination Period.)

CARE DIRECTIONS FAMILY ADVICE AND ADVOCACY PROGRAM®

The Care Directions Family Advice and Advocacy Program® is an added benefit offered to You and Your Family. The program is staffed by Personal Care Advisors, who are health care professionals chosen by Us, whose profession and training include experience or expertise in managing and arranging for long term care services. Where required, Our Personal Care Advisor will be licensed and acting within the scope of that license.

CARE PARTNER

A Care Partner is any policyholder who is a Spouse or Domestic Partner.

CASH BENEFIT ACCOUNT

The Cash Benefit Account is the total amount of Benefits payable under this Policy.

CHRONICALLY ILL

Chronically Ill means that as the result of an Assessment You have been certified by a Licensed Health Care Practitioner as having a chronic illness or disability that causes You to:

a) Require Substantial Assistance with at least two Activities of Daily Living expected to last at least 90 days, or
b) Have a Severe Cognitive Impairment that requires Substantial Supervision.

DOMESTIC PARTNER

Domestic Partners are persons at least 18 years of age, of the same or opposite sex in an exclusive and committed relationship. They must have lived together for at least 12 months in a common household and have an exclusive mutual commitment, including financial interdependence, similar to that of marriage.

ELIMINATION PERIOD

The Elimination Period is the number of calendar days You must wait before You will receive Benefits. Your Elimination Period begins the earliest of the date We have verified You are Chronically Ill and have a Plan of Care or the date You contact Us to establish Benefit Eligibility.

The Elimination Period will end after the number of days chosen by You and shown in Your Schedule of Policy Benefits has ended. Benefits are not payable during the Elimination Period except where the Policy so states.

Days in an Elimination Period are combined, and do not need to be consecutive. You need to meet Your Policy's Elimination Period only once.

HOSPICE CARE PROGRAM

A state or federally licensed, accredited or certified program that provides a program of care designed to provide palliative care with the philosophy of alleviating the physical, emotional, and spiritual discomforts of a person who:

a) Is in the last phases of life due to a terminal disease; and
b) Has a physician-certified prognosis of less than 6 months to live.

The program must be administered by an interdisciplinary team that consists of a physician, a registered nurse, clergy or counselors, trained volunteers and other appropriate staff having expertise in meeting the needs of terminal patients.

Hospice Care Program services may be provided in a Qualified Facility or in Your Home.

LICENSED HEALTH CARE PRACTITIONER

A Licensed Health Care Practitioner means any of the following other than a family member: a physician (as defined in Section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or another professional individual who meets the requirements prescribed by the United States Secretary of the Treasury.

MONTHLY CASH BENEFIT

This is the amount We will pay in a single month for the Benefits You have chosen. The Monthly Cash Benefit You have chosen is stated in Your Schedule of Policy Benefits.

PERSONAL CARE ADVISOR

This is a health care professional chosen by Us whose profession and training includes experience or expertise in managing and arranging for long term care services. These services are optional and are provided at no cost to You. Where required, he or she must be licensed and acting within the scope of that license.

PLAN OF CARE

This is a written, individualized plan for care and support services for You that:

1. Has been prescribed by a Licensed Health Care Practitioner; and
2. Has been developed as a result of an Assessment and incorporates any information provided by Your personal physician; and
3. Fairly, accurately and appropriately addresses Your long term care and support service needs; and
4. Specifies the type, frequency and duration of all services required to meet those needs and the providers appropriate to furnish those services.

A Plan of Care is completed at the same time the Assessment is performed.

POLICY

This is a legal agreement between You and Us. It includes this document, Your application, and any attached riders or endorsements.

POLICY ANNIVERSARY DATE

This is the date each year that coincides with the date this Policy went into effect. The first Policy Anniversary Date will be one year from the date the Policy went into effect.

QUALIFIED FACILITY

A Qualified Facility is a state or federally regulated, licensed, accredited or certified facility as defined by Arkansas law that meets all of the following criteria. If a facility is not state or federally regulated, licensed, accredited or certified, it must meet all of the following criteria to be considered a Qualified Facility:

- Provides accommodations to 3 or more unrelated individuals and supervision and personal care services for at least 3 of these individuals; and
- Provides 24-hour-a-day care and services; and
- Has a trained, awake, and ready-to-respond employee on duty in the facility at all times to provide necessary care; and
- Provides 2 meals a day and accommodates special dietary needs; and
- Conducts an assessment of the resident on admission that includes a history and physical by a physician, nurse practitioner, or physician assistant in the last 60 days, the resident's ability to perform both instrumental activities of daily living and activities of daily living, safety evaluation, risk of fall assessment, cognitive assessment, and the resident's ability to manage medication administration; and
- Develops a Plan of Care or service plan for each resident that is customized to the resident and includes both the services provided by or contracted by the residence and identifies services that will be provided by outside agencies directly contracted with the insured including the scope of services, frequency of services and monitoring of services delivered; and
- Reviews the service plan at least every six months or as the resident's needs change.

A Qualified Facility must meet the above criteria for the Benefits to be paid at the Facility Monthly Cash Benefit; otherwise, the Community Monthly Cash Benefit will apply.

A Qualified Facility is NOT:

- A hospital or clinic; or
- A place that operates primarily for the treatment of alcoholism, drug addiction or mental illness;
- An Adult Day Care or similar establishment.

QUALIFIED LONG-TERM CARE SERVICES

These are the necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, as well as maintenance or personal care services, which (a) are required by a person who is Benefit Eligible as described in this Policy and (b) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

The following is a partial list of services that meet the above definition. There are many other services that may also qualify. Should You need assistance in deciding on or obtaining care, Your Personal Care Advisor may be able to help.

- Home Health Care,
- Homemaker Services
- Adult Day Care
- Caregiver training
- Care Coordination and Advisement
- Assistive Devices
- Home modification
- Therapy
- Care provided by family members
- Assisted Living, Residential & Personal Care Facilities
- Caregiver time off - respite care
- Nursing Home
- Hospice Care
- Meals on Wheels
- Transportation
- Durable medical equipment

SEVERE COGNITIVE IMPAIRMENT

Severe Cognitive Impairment means a deterioration or irreversible loss in intellectual capacity that requires Substantial Supervision to assure You and others' safety. The deterioration or loss is established by clinical evidence and standardized tests that reliably measure:

- short-term or long-term memory;
- orientation as to people, place, or time;
- deductive or abstract reasoning; and
- judgement as it relates to safety awareness.

SPOUSE

A Spouse is a married policyholder or the person to whom they are married. The marriage must be recognized as legal in accordance with the laws of the state in which this Policy is sold.

SUBSTANTIAL ASSISTANCE

There are two types of Substantial Assistance.

1. *Hands-on Assistance:* The physical assistance of another person without which an individual could not perform an Activity of Daily Living, or
2. *Stand-by Assistance:* The presence of another person within arm's reach necessary to prevent, by physical intervention, injury to an individual while they are performing an Activity of Daily Living.

SUBSTANTIAL SUPERVISION

This is continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and that is necessary to protect You from threats to Your health or safety.

WE, US, OUR

These refer to MedAmerica Insurance Company when used in this Policy.

YOU, YOUR, YOURSELF	This refers to the person insured under this Policy and whose name appears in the Schedule of Policy Benefits.

PART 1: BENEFITS

Below are descriptions of the Benefits under this Policy.

Benefits are described in this Policy or the Riders attached to it. Benefit and Rider limits and effective dates are stated on the Schedule of Policy Benefits.

FACILITY BENEFITS

NOTE: This Section does not apply if You have elected the Facility Only or Community Only Rider.

The Facility Monthly Cash Benefit will be paid each month if:

a) You are Benefit Eligible* ; and
b) You reside in a Qualified Facility; or
c) You receive care under a Hospice Care Program.

* If You are receiving care under a Hospice Care Program, Benefit Eligibility does not require You to satisfy Your Elimination Period for payments to be made.

Payments of Facility Monthly Cash Benefits will reduce Your Cash Benefit Account.

COMMUNITY BENEFITS

NOTE: This Section does not apply if You have elected the Facility Only or Community Only Rider.

The Community Monthly Cash Benefit will be paid each month if:

a) You are Benefit Eligible; and
b) You do not reside in a Qualified Facility.

Payments of Community Monthly Cash Benefits will reduce Your Cash Benefit Account.

ADDITIONAL POLICY BENEFITS AND FEATURES

PERSONAL CARE ADVISOR SERVICES

CARE DIRECTIONS FAMILY ADVICE AND ADVOCACY PROGRAM®

The value of Your Policy goes beyond covering the cost of services. We can provide You with advice on accessing and tailoring Your coverage to meet Your particular needs before or while You are Benefit Eligible. You may use the services of Our Care Directions Family Advice and Advocacy Program® at any time. These services are optional and are provided at no cost to You. Our Personal Care Advisors are professionals who can help You and/or Your family members plan for Your care. From assisting in developing a written Plan of Care when You establish Your claim to monitoring Your needs on an ongoing basis, Care Directions® Personal Care Advisors will provide You with their support.

In addition to helping with the planning and monitoring of Your care, Our Personal Care Advisors can also help You locate long term care services. We do not guarantee the services of any particular provider, nor the quality of care You may receive, but We will work with You and/or Your family to find the type of care You choose.

Services provided under the Care Directions Family Advice and Advocacy Program® are not subject to the Elimination Period. Using them will not reduce Your Cash Benefit Account.

OTHER GOODS AND SERVICES

From time to time, We may offer or provide certain goods and services in addition to insurance coverage. We may also arrange for third party vendors to provide goods and services at a discount including without limitation, beneficiary financial counseling services and employee assistance programs to You. Though We may make the arrangements, the third party vendors are solely liable for providing the goods and services. We shall not be responsible for providing or failing to provide the goods and services. Further, We shall not be liable for the negligent provision of the goods and services by third party vendors.

WAIVER OF PREMIUMS

The premiums for this Policy will be waived the day after the date the Elimination Period is met. The waiver ends on the date We determine You are no longer Benefit Eligible.

This Section is modified if You have elected the Shared Waiver and/or the Survivor Riders. Please see Your Shared Waiver and/or Survivor Riders for details of Your coverage under those Riders.

The above does not apply if premiums are no longer payable.

PART 2: ELIGIBILITY FOR PAYMENT OF BENEFITS

ESTABLISHING BENEFIT ELIGIBILITY

To start the process of establishing Benefit Eligibility, You should contact Us. If You think You might be Chronically Ill, please call Our Customer Service Representative at [1-800-544-0327].

We will work with You, Your family and Your physician to arrange the Assessment and obtain any other needed information about your condition. This information will be gathered by Us or one of Our representatives at no cost to You.

You will also need a Plan of Care. The Plan of Care is updated as Your needs change. You may use the services of Our Personal Care Advisors. These services are provided at no cost to You. We will review Your Assessment to verify You are Chronically Ill. You may contact Us with any questions regarding Our decision.

To continue Benefit Eligibility, We must verify You are Chronically Ill and have an updated Plan of Care at least every 12 months.

NOTICE OF CLAIM

When You become Benefit Eligible, You or Your representative must submit a completed Request for Benefits form each month to receive Your Monthly Cash Benefit payment. Request for Benefits forms can be obtained by calling or writing Our Customer Service area.

You do not have to submit provider bills to claim benefits.

If We do not receive a completed Request for Benefits form from You for more than 90 days, You must re-establish Your Benefit Eligibility. You may contact Our Customer Service Representatives for assistance in re-establishing Your eligibility for Benefits.

PAYMENT OF CLAIM

Benefit payments will be payable prospectively from the day after the date You become Benefit Eligible. Thereafter, as long as You remain Benefit Eligible and submit Your claim, You will be paid Your Benefits on a monthly basis. These Benefit payments are intended to be used for Qualified Long Term Care Services.

Named Payee: While You are living, all Benefits will be paid to You unless there is an Assignment of Benefits to a Named Payee. An Assignment of Benefits is Your or Your legal representative's request for payments to be sent to someone other than You. An Assignment of Benefits cannot be irrevocable and You may change the Named Payee at any time. If You or Your legal representative wishes to have Benefit payments sent to another individual, We must receive the Assignment of Benefits request in writing no later than the time Your claim is submitted. No Assignment of Benefits will be considered valid unless it has been received in writing by Our administrative office. Unassigned Benefits due and unpaid at Your death will be paid to Your estate.

Currency: Benefits will be paid in US currency.

WHEN YOU HAVE CLAIMS QUESTIONS

If You would like an explanation of Our claim payment, please call or write to us.

APPEALS

If We contest a claim or a portion of a claim, You or Your legal representative will be notified in writing that the claim is contested or denied.

You have a right to appeal Our claims decision. The appeal must be filed in writing with Our office within 3 years of the time the denied claim being appealed was filed. Include the reason for the appeal and any documents You feel are pertinent to the situation.

We will send You a written acknowledgement of Your appeal. If no additional information is needed, the acknowledgement will include an explanation of the denial. If additional information is required, We will explain what is needed. If We do not receive the requested information within 21 days, We will notify You in writing.

Within 60 days of the receipt of required information, We will notify You in writing of the outcome of the reconsideration of Your claim, and the contested claim or portion thereof that will be paid or denied.

TIME LIMIT FOR LEGAL ACTION

You may not begin legal action against Us to recover Benefits under this Policy until at least 60 days has passed since Your claim was submitted to Us. No such action may be brought more than 3 years after the claim is furnished.

RECOVERY OF OVERPAYMENT

If, due to an error in processing, a claim results in an overpayment, We will explain the overpayment to You. You must return the amount of overpayment within 60 days of Our request. Any overpayment that is not returned to Us within 60 days of Our request will be deducted from future claim payments.

WORLDWIDE COVERAGE

You may receive Benefits anywhere in the world.

PART 3: POLICY EXCLUSION

POLICY EXCLUSION

Benefits are not payable if Your Chronic Illness is due to War or any act of war, declared or undeclared.

PART 4: PREMIUM

PREMIUM AMOUNT

The initial premium is shown in Your Schedule of Policy Benefits. It will remain the same unless You change the coverage or We change the premium. If We change the premium, We will notify You at least 45 days in advance. No change will be made to the premium amount unless We change the premium rates for all Policies like Yours that We have issued in the state where this Policy has been approved and, where applicable, Your State Department of Insurance has approved the increase.

The above does not apply if premiums are no longer payable.

PAYMENT

Premiums are due in advance.

GRACE PERIOD

An initial Grace Period of 31 days will be granted for each premium that is unpaid on the date due. After the initial Grace Period of 31 days elapses, a notice will be sent to You explaining that a payment has been missed and that Your Policy risks lapsing. If You have designated an individual to be notified in case of lapse, We will also send notice to the address provided for that designee. You will have an additional 35 days Grace Period that begins the date We mail the notice to pay the unpaid premium.

Payment will allow this Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of the second Grace Period will result in the termination of Your Policy as of the premium due date.

Lapse Designee: If You have designated an individual to be notified of lapse, We will provide You the opportunity, no less frequently than every 2 years, to change such designation.

The above provisions do not apply if premiums are no longer payable.

REINSTATEMENT

If this Policy lapses because You did not pay the premium within the Grace Period, You may request reinstatement with no break in coverage. If We honor this request, the Policy will be reinstated back to the termination date. If We do not approve or disapprove the request within 45 days of receipt of the request and a premium was accepted by Us or one of Our authorized representatives, the Policy will be reinstated as of the date the Policy terminated.

The above does not apply if premiums are no longer payable.

EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY

You may request reinstatement up to 5 months after termination if You did not pay the premium due to a condition that would qualify You for Benefits. Your condition is subject to verification. An Assessment is required before deciding on reinstatement. If reinstated, You must pay the premium retroactive to the date the Policy terminated.

The above does not apply if premiums are no longer payable.

UNEARNED PREMIUM

When We are notified of Your death or the cancellation of this Policy, We will refund any premium paid for the period beyond such notification.

All premiums paid for the period beyond Your death will be refunded.

- Your premiums will be refunded to Your Beneficiary. In the absence of a named Beneficiary, we will refund unearned premium to Your estate.

In the event of the cancellation of this Policy, premiums paid for the period beyond such cancellation will be refunded to You.

The above does not apply if premiums are no longer payable.

RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS

You may, at any time, ask for a decrease in Your coverage. Your request for a decrease in coverage must be made in writing and Your reduced premium will be based on Your age at the time Your original Policy was issued.

We will provide written notice to You, during Your Grace Period, of Your option to reduce coverage to lower Your premium.

PART 5: GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Policy document, Your application and any Riders and attached papers establish the entire contract of insurance between You and Us. Any change must be approved by one of Our officers and mutually agreed to by You. It must also be endorsed on or attached to this Policy. No insurance producer has the authority to change this Policy or to waive any of its provisions.

YOUR BENEFITS

This Section is modified if You have elected the Shared Waiver and/or Shared Care Benefit Riders. Please see Your Shared Waiver and/or Shared Care Rider details of Your coverage under those Riders.

With the exception of a Named Payee or Your estate, only You are eligible for Benefit payments other than returned premiums under this Policy.

WHEN POLICY COVERAGE BEGINS

This Policy begins on the date shown in the Schedule of Policy Benefits. All time periods begin on that date at 12:01 a.m. standard time at Your residence.

WHEN POLICY COVERAGE ENDS

This Policy ends and Benefits will not be available on the day after the date one of the following occurs:

- Nonpayment of premium (subject to the Grace Period); or
- The Cash Benefit Account is exhausted; or
- You elect to cancel this Policy; or
- Your death.

All time periods begin on that date at 12:01 a.m. standard time at Your residence.

EXTENSION OF BENEFITS

If You are Benefit Eligible on the date this Policy is cancelled, We will continue to pay the applicable Monthly Cash Benefit without interruption until the first of the following dates:

- It is determined that You are no longer Benefit Eligible under this Policy; or
- The Cash Benefit Account is exhausted.

We will not pay more than You would have been entitled to receive if the Policy had not terminated.

INCONTESTABLE PERIOD

We may rescind this Policy or deny a claim during the first 6 months of the Policy if it can be shown that a misrepresentation by You was material to Our acceptance of You.

After 6 months but before 2 years, We may rescind this Policy or deny a claim if it is shown that a misrepresentation by You both was material to Our acceptance of You and pertained to the condition for which Benefits are sought.

After 2 years, We may rescind this Policy or deny a claim only if it is shown that You knowingly and intentionally misrepresented relevant facts relating to Your health or due to non-payment of premiums.

These provisions also apply if You provide additional evidence of insurability to purchase additional coverage after the Policy Effective Date.

CLERICAL ERROR

Clerical error, whether by You or Us, will not void Your insurance if the insurance would otherwise have been in effect. Neither will it extend the insurance if the insurance would otherwise have ended or been reduced as provided in this Policy.

MISSTATEMENT OF FACT

If Your age, eligibility or information regarding Your Care Partner status was misstated on Your Application, the premium for this Policy will be changed retroactive to the original effective date to correspond to:

a) Your correct age;
b) Your correct eligibility category; and/or
c) Your actual Care Partner status.

Our liability will be limited to a refund of the premiums paid for this Policy if:

1. Your application would have been declined if Your age was not misstated; or
2. You would have been subject to additional evidence of insurability.

NON-PARTICIPATING

This Policy does not participate in Our profits or surplus earnings.

TAX STATUS OF PREMIUMS AND BENEFITS

This Policy is intended to be a Qualified Long Term Care Insurance Contract as defined by the Internal Revenue Code Section 7702B(b). The Benefits under this Policy are paid without regard to the type and amount of expenses You may have. Generally, if the Benefits paid under a Policy exceed the per diem limit as prescribed in law, they could be considered taxable income. You should consult Your tax advisor with respect to the potential tax implications of ownership of this Policy.

COMMUNICATION THROUGH ELECTRONIC MEANS

We reserve the right to designate the form and means of all communications or notices required by this Policy.

If We agree, You may contact Us about Your Policy using electronic means or technologies.

If You agree, We may contact You regarding this Policy using electronic means or technologies.

Except where barred by state or federal law, electronic communication is equal to other communication methods. Information exchanged has the same legal effect, validity, and enforceability.

CONFORMITY WITH FEDERAL AND STATE STATUTES

If on this Policy's Effective Date, any part conflicts with federal statutes or statutes in the state You live in, this Policy is hereby amended to conform to the minimum requirement of such statutes.

If changes are necessary in order to maintain the tax-qualified status of this Policy, We will provide You with the opportunity to accept or reject the necessary amendments to this Policy.

PART 6: CONTINGENT NON-FORFEITURE PROVISIONS*

If You have NOT selected the Shortened Benefit Period Option, the following Contingent Non-Forfeiture provisions apply. These provisions change the coverage to provide options in the event this Policy ends due to non-payment of premium after a Substantial Premium Increase.

A Substantial Premium Increase is one that results in a cumulative increase to the annual premium that is equal to or exceeds a certain percentage of the original premium. It does not include premium increases that result from a voluntary purchase of additional coverage. The limits of cumulative increase as a percentage of the annual premium are based on Your age as of the Policy Effective Date shown in Your Schedule of Policy Benefits. The following table shows the cumulative increase that will trigger the Contingent Non-Forfeiture Provision.

*This section shall apply only where premiums are payable. Rights under Contingent Non-Forfeiture Provisions are not available where current and future premiums are neither due nor owing.

SUBSTANTIAL PREMIUM INCREASE TABLE

POLICY ISSUE AGE	PERCENT OF INCREASE	POLICY ISSUE AGE	PERCENT OF INCREASE
Less than 30	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

A. Contingent Nonforfeiture Benefit Option: You will be notified of any Substantial Premium Increase 45 days prior to the change of Your premium. The notice will include the amount of the premium, its due date, and the following contingency options in the event of lapse.

1. Alternative Benefit options at a lower premium
2. A lesser Cash Benefit Account with no further premium required. You will have 120 days following the premium due date to elect this option. Under this option, the same Monthly Cash Benefit amounts in effect at the time of lapse will be payable, but the Cash Benefit Account will be equal to the greater of items a) or b) below.
    a) The total amount of premiums paid for Your Policy
    b) Your Monthly Cash Benefit

The total of all Benefits paid under Your Policy will not exceed the Cash Benefit Account that would have been payable if Your Policy did not lapse.

Option 2 will automatically take effect if all of the following apply.

1. Your Policy lapses within 120 days of the premium due date for the Substantially Increased Premium; and
2. You have not made an election.

B. **Reduced "Paid Up" Contingent Nonforfeiture Benefit Option:** In addition to the Contingent Nonforfeiture Benefits Option (A) described above, the following Reduced "Paid-up" Contingent Nonforfeiture Benefit is an option if You have chosen the 10 year or Paid Up at Age 65 payment option, even if You selected the Shortened Benefit Period option when You purchased Your Policy. You are eligible for the reduced "paid up" contingent nonforfeiture benefit without the requirements of additional underwriting when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65 – 80	30%
Over 80	10%

2. You stop paying premiums within 120 days of when the premium increase took effect; **AND**

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If You exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The limited pay Contingent Benefit can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
b. The monthly benefit amounts you purchased will be adjusted by the same ratio.

If both the Contingent Nonforfeiture Benefit (A) and the Reduced "Paid up" Contingent Nonforfeiture Benefit (B) are triggered by the same rate increase, you can choose either of the two options. If You have not made an election, the Reduced "Paid Up" option (B) will take effect if sufficient premium has been paid to make it available.

MEDAmerica INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

[Administrative Offices:]
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

Things You Should Know Before You Buy Long Term Care Insurance

Long-Term Care Insurance

- A long term care insurance policy may pay most of the costs for your care
- in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long term care if you have very little income and few assets. You should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local County Department of Social Services.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of the appropriate Shopper's Guide regarding Long Term Care Insurance approved by Your States Commissioner of Insurance. Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

SERFF Tracking Number:	*MEAM-125712760*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*39444*
Company Tracking Number:	*SPL2-336-AR-0708*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SPL2-336-AR-0708*		
Project Name/Number:	*NAIC Model Filing/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MEAM-125712760*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*39444*
Company Tracking Number:	*SPL2-336-AR-0708*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SPL2-336-AR-0708*		
Project Name/Number:	*NAIC Model Filing/*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Certification/Notice 06/26/2008
Bypass Reason: N/A
Comments:

Review Status:

Satisfied -Name: Application 06/26/2008
Comments:
Attachments:
S2-345-AR-0708.pdf
S2-346-AR-0708.pdf

Review Status:

Bypassed -Name: Health - Actuarial Justification 06/26/2008
Bypass Reason: N/A
Comments:

Review Status:

Satisfied -Name: Outline of Coverage 06/26/2008
Comments:
Attachment:
S2-151-AR-0708.pdf

Review Status:

Satisfied -Name: Cover Letter 06/26/2008
Comments:
Attachment:
Cover Letter.pdf

Review Status:

Satisfied -Name: Issuer Certification Form 06/26/2008
Comments:

SERFF Tracking Number:	*MEAM-125712760*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*39444*
Company Tracking Number:	*SPL2-336-AR-0708*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SPL2-336-AR-0708*		
Project Name/Number:	*NAIC Model Filing/*		

Attachment:

Certification Form.pdf

SERFF Tracking Number:	*MEAM-125712760*	*State:*	*Arkansas*
Filing Company:	*MedAmerica Insurance Company*	*State Tracking Number:*	*39444*
Company Tracking Number:	*SPL2-336-AR-0708*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SPL2-336-AR-0708*		
Project Name/Number:	*NAIC Model Filing/*		

Review Status:

Satisfied -Name: Forms List 06/26/2008

Comments:

Attachment:

FORMS LIST-AR-0708.pdf

Review Status:

Satisfied -Name: Red-Lined Pages 06/26/2008

Comments:

Attachment:

Red-Lined Pages.pdf

MEDAmerica INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

[Administrative Offices:]
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

Simplicity^{ii}

Long Term Care Insurance
TAX QUALIFIED COVERAGE

STANDARD APPLICATION
SPL2-336-AR

❒ NEW POLICY
❒ COVERAGE INCREASE
Indicate your current policy number here: _____

Choose One: ☐ **Individual** ☐ **Affiliation: Affiliation/Employer Name:** _____
Company Assigned Number: _____

I. APPLICANT INFORMATION: 5 Questions to Complete

1. IDENTIFYING INFORMATION

Applicant Name (First, MI, Last)			Social Security Number
Legal Residence Street Address (PO Box Not Adequate-Must Provide Street)			**Mailing/Delivery Street Address (if different)**
City **State** **Zip**			**City** **State** **Zip**
( )	( )	☐ AM ☐ PM	
Home Phone	**Work Phone**	**Best Time to Call**	**Email**

____/____/____ MM / DD / YYYY		☐ Male ☐ Female	Ft. In.	Lbs.
Date of Birth	**Age (On Date Signed)**	**Sex**	**Ht. (Check BMI Table)**	**Wt**

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Single with Care Partner* ☐ Widowed with Care Partner*
If you are Widowed or Single and applying for the Care Partner Premium, the Care Partner Statement must be signed.

2. CARE PARTNER (Spouse/Domestic Partner) INFORMATION

a) Is your Care Partner (Spouse/Domestic Partner) applying for coverage at this time? ☐ YES* ☐ NO **If YES, answer (c)**
b) Does your Care Partner (Spouse /Domestic Partner) have a MedAmerica policy? ☐ YES* ☐ NO **If YES, answer (c)**
c) Care Partner (Spouse /Domestic Partner) name and SS# : _____ __ __ __ - __ __ - __ __ __ __
Name (First, MI, Last) Social Security Number

* ***Single or Widowed Care Partners must complete the Care Partner Statement.***

3. ALTERNATE EFFECTIVE DATE

☐ **Same as Care Partner (Spouse/Domestic Partner)** ☐ **Other:** _____ **Refer to Conditional Receipt.**

4. ALTERNATE BILLING ADDRESS: Address that applicant is requesting billing be mailed to IF different than the Applicant Address.

Name (First, MI, Last)			( ) Phone Number
Street Address	**City**	**State**	**Zip**

5. BENEFICIARY (optional) A Beneficiary is a person(s) named by You to receive any premiums that may be due in the event of Your death.

Beneficiary Name (First, MI, Last)	Relationship	( ) Phone Number
Street Address	**City**	**State** **Zip**

OFFICE USE ONLY App. Rec: _____ App Status: _____ UW Date: _____ Init: _____
☐ **Preferred** ☐ **Standard** **Effective Date**: _____

COMPLETE AND RETURN

II. POLICY BENEFIT SELECTION: 7 Steps to Complete

STEP 1: SELECT TYPE OF COVERAGE: A. , B. , OR C.

A. ☐ COMPREHENSIVE COVERAGE

STEP 2: CASH BENEFIT ACCOUNT (Choose One)	STEP 3: MONTHLY CASH BENEFIT (Choose One from Same Row as Cash Benefit Account)			
	MONTHLY CASH BENEFIT	EFB: [1] Increase Facility Benefit to:	MONTHLY CASH BENEFIT	EFB: [1] Increase Facility Benefit to:
☐ $100,000 2 Options: a or b	a. ☐ $1,500	☐ EFB $2,000		
	b. ☐ $3,000 [2]	☐ EFB $4,000		
☐ $200,000 4 Options: a, b, c, or d	a. ☐ $1,500	☐ EFB $2,000	c. ☐ $4,500	☐ EFB $6,000
	b. ☐ $3,000	☐ EFB $4,000	d. ☐ $6,000 [2]	☐ EFB $8,000
☐ $300,000 4 Options: a, b, c, or d	a. ☐ $3,000	☐ EFB $4,000	c. ☐ $6,000	☐ EFB $8,000
	b. ☐ $4,500	☐ EFB $6,000	d. ☐ $7,500	☐ EFB $10,000 [2]
☐ $500,000 4 Options: a, b, c, or d	a. ☐ $4,500	☐ EFB $6,000	c. ☐ $7,500	☐ EFB $10,000
	b. ☐ $6,000	☐ EFB $8,000	d. ☐ $9,000	☐ EFB $12,000
☐ $1,000,000 4 Options: a, b, c, or d	a. ☐ $6,000	☐ EFB $8,000	c. ☐ $9,000	☐ EFB $12,000
	b. ☐ $7,500	☐ EFB $10,000	d. ☐ $12,000	☐ EFB $16,000

[1] **EFB- ENHANCED FACILITY BENEFIT (Optional): If Selected Increases Facility Coverage to EFB Amount Indicated**

[2] **Shared Care Rider is Not Available with these Combinations**

B. ☐ COMMUNITY ONLY (Initials Required Below) Shared Care Rider is Not Available

STEP 2: CASH BENEFIT ACCOUNT (Choose a, b, or c)	STEP 3: MONTHLY CASH BENEFIT Choose a, b, or c from SAME Row as Cash Benefit Account
a. ☐ $100,000	a. ☐ $1,500 b. ☐ $3,000
b. ☐ $200,000 c. ☐ $300,000	a. ☐ $3,000 b. ☐ $4,500 c. ☐ $6,000

Initials Required: I have elected to purchase the Community Only Rider. I understand that by choosing this Rider, I am limiting my coverage to care provided when **I do not reside in a Qualified Facility.** I may not have coverage for all the types of long term care services I might require. ***Initial Here*** ☛

C. ☐ FACILITY ONLY (Initials Required Below) Shared Care Rider is Not Available

STEP 2: CASH BENEFIT ACCOUNT (Choose a, b, c, d, or e)	STEP 3: MONTHLY CASH BENEFIT Choose One From Same Row as Cash Benefit Account
a. ☐ $200,000 b. ☐ $300,000	a. ☐ $3,000 b. ☐ $4,500 c. ☐ $6,000
c. ☐ $500,000 d. ☐ $1,000,000	a. ☐ $6,000 b. ☐ $7,500 c. ☐ $9,000

Initials Required: I have elected to purchase the Facility Only Rider. I understand that by choosing this Rider, I am limiting my coverage to care provided when **I reside in a Qualified Facility**. I may not have coverage for all the types of long term care services I might require. ***Initial Here*** ☛

STEP 4: ELIMINATION PERIOD Choose One	STEP 5: INFLATION Choose One	STEP 6: PREMIUM PAYMENT OPTIONS Choose One
☐ 30 Days	☐ 5% Simple ☐ None	☐ Lifetime
☐ 60 Days	☐ 3% Compound: No Max	☐ 10 Pay
☐ 90 Days	☐ 5% Compound: No Max	☐ Paid Up at Age 65 [3]
☐ 180 Days	☐ 5% Compound 2x Max	[3] Not available after age 55

II. POLICY BENEFIT SELECTION (Continued)

STEP 7: RIDERS: Riders are available only at the time of Original Purchase Unless otherwise stated.		Check Riders You Are Applying For
Shared Care Rider [4]	*Policies must be identical in benefits and premium payment options.* *Also **not** available with:* • *Restoration of Benefits Rider;* • *Comprehensive Coverage $100,000 Cash Benefit Account and $3,000 Monthly Cash Benefit;* • *Comprehensive Coverage $200,000 Cash Benefit Account and $6,000 Monthly Cash Benefit;* • *Comprehensive Coverage $300,000 Cash Benefit Account and $10,000 Enhanced Facility Benefit*	☐
Shared Waiver Rider [4]	• ***Not** available if Care Partners' age difference is more than 15 years.*	☐
Survivor Benefit Rider [4]	• ***Not** available if Care Partners' age difference is more than 15 years* • ***Not** available with 10 Pay Premium Payment Option.*	☐
	[4] *For all of the above Shared Riders:* • ***Not** available with Community Only or Facility Only* • *Both Care Partners Must Purchase the Riders and the Riders must have the Same Effective Date.* • *If one Care Partner is Not Eligible or Does Not Apply, they must apply within 6 months of the Original Care Partner and the Original Care Partner can not be Eligible for Benefits at the time the Rider is requested.*	
[Restoration of Benefits Rider	• ***Not** Available with Community Only* • ***Not** available with Shared Care Rider.*	☐**]**
Non-forfeiture Riders	**[Return of Premium Rider:** *Available to Applicants **Age 75 and Under**. **Not** available with Community Only Rider OR Full Return of Premium Rider*	☐**]**
	[Full Return of Premium Rider: *Available to Applicants **Age 65 and Under**. **Not** available with Community Only Rider OR Return of Premium Rider*	☐**]**
	Shortened Benefit Period Rider	☐

III. INSURANCE HISTORY

1. Are you covered by a state assistance program (Medicaid)?
If YES, as a Medicaid recipient you probably should not apply for this coverage. We recommend ending the application at this point. ☐ **YES** ☐ **NO**

2. Do you currently or have you had in the last 12 months another nursing home (NH), home health care, long term care insurance policy, rider or certificate in force? **If Lapsed, Provide Term Date** ☐ **YES** ☐ **NO**

If YES, please provide the following information. (Please use extra paper if needed)

2a). **Company Name**	**Address (Street, City, State, Zip)**			**Policy Type:** ☐ NH & Home Care ☐ NH Only ☐ Home Care Only	
Still In Force ☐ Yes ☐ No	**Policy Number**	**Daily Benefit Amount**	**Years Coverage**	**Effective Date**	**Term Date**

2b). **Company Name**	**Address (Street, City, State, Zip)**			**Policy Type:** ☐ NH & Home Care ☐ NH Only ☐ Home Care Only	
Still In Force ☐ Yes ☐ No	**Policy Number**	**Daily Benefit Amount**	**Years Coverage**	**Effective Date**	**Term Date**

3. Are you allowing any other nursing home (NH), home health care, long term care insurance policy, rider or certificate to lapse or do you intend to replace any other nursing home, home health care, long term care insurance policy, rider or certificate with this policy? **If Lapsed, Provide Term Date** ☐ **YES** ☐ **NO**

If YES, You must sign both Notices Regarding Replacement of Accident and Sickness or Long term Care Insurance Forms. Submit Company Copy with this Application and retain the Applicant Copy.

Company Name	**Address (Street, City, State, Zip)**			**Policy Type:** ☐ NH & Home Care ☐ NH Only ☐ Home Care Only	
Still In Force ☐ Yes ☐ No	**Policy Number**	**Daily Benefit Amount**	**Years Coverage**	**Effective Date**	**Term Date**

IV. PREMIUM PAYMENT INFORMATION: All Applicants must CHOOSE ONE method and complete required information.

1. ☐ DIRECT BILL

Select the frequency of your Direct Billing payment

☐ Quarterly

☐ Semi-Annual

☐ Annual

2. ☐ ELECTRONIC FUNDS TRANSFER (EFT)

Select the frequency of your EFT payment.

☐Monthly ☐Quarterly ☐Semi-Annual ☐ Annual

_____

Bank Name

_____ _____

Bank Account Number **Routing Number (9 numbers)**

Requires Minimum of 2 months Conditional Premium. Attach Voided Check if Requesting EFT from Different Bank Account than Conditional Premium Check.

***Sign Authorization Below**

3. ☐ CREDIT CARD

Select the frequency of your Credit Card payment

☐Monthly ☐Quarterly ☐Semi-Annual ☐ Annual

☐ **VISA** ☐ **MASTERCARD**

_____

Credit Card Number

_____

Expiration Date MM/YY

***Sign Authorization Below**

***Authorization for EFT and Credit Card: Required IF Choosing EFT OR Credit Card Payment Method**

I authorize my financial institution or credit card company to automatically make payments to MedAmerica Insurance Company for my insurance. This authorization shall remain in force until I give notification of termination to my financial institution and MedAmerica Insurance Company in writing.

☛_____

Account Holder Signature

☛_____

Joint Account Holder Signature

4. ☐ 100% Affiliation/Employer Paid

(Your Employer is Paying all the Premium for the Benefits Chosen)

5. ☐ PAYROLL DEDUCTION (Available only if approved by Affiliation/Employer)

I authorize my Affiliation/Employer to deduct the applicable premium from my salary. I may revoke this authorization at any time by written notice to my Affiliation/Employer and to MedAmerica Insurance Company.

_____

Print Name of Employee/Member (First, Last Name)

☛_____

Employee/Member Signature

[_____]

[Eligible Census ID -SSN, Employee ID or DOB]

[Required if Employee/Member is NOT the Applicant]

V. INSURABILITY PROFILE-MUST BE COMPLETED BY ALL APPLICANTS

[SPEEDApp℠]

INSTRUCTIONS: You must answer each question by **checking YES or NO.**

1. Have you ever received Medical Advice, Consultation, or Treatment for any of the following conditions: ☐ YES ☐ NO

- Alzheimer's Disease, Lewy Body Disease, Dementia, Any Memory Problems, Psychosis, Schizophrenia, Mental Retardation
- Amytrophic Lateral Sclerosis (ALS), Myasthenia Gravis, Multiple Sclerosis, Parkinson's Disease/Parkinsonism
- Post-Polio Syndrome, Demyelinating Disease, Other Neurological Conditions affecting the brain or spinal cord
- Lupus (SLE), Mixed Connective Tissue Disease, Scleroderma, Muscular Dystrophy, Other Muscular Conditions Causing Limits
- Kidney Disease, Polycystic Kidney Disease, Liver Cirrhosis, Hepatitis, Hemachromatosis
- Amputation-Due to Disease, Double Heart Valve Replacement , Organ or Bone Marrow Transplants
- Brain or Spinal Tumors-benign or malignant, Multiple Myeloma
- Peripheral Vascular Disease **and** Smoking, Peripheral Vascular Disease **and** Diabetes, Skin Ulcers **and** Diabetes
- 2 or more Strokes or Transient Ischemic Attacks(TIAs), Single Stroke OR TIA **and** Diabetes
- AIDS- *You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS.*

2. In the past year have you needed assistance or supervision in performing activities of daily living*, used any Medical Equipment**, or received nursing home care, home health care, assisted living care, or adult day care services? ☐ YES ☐ NO

***Activities of Daily Living Include Walking, Dressing, Eating, Toileting, Taking Medications, Getting In and Out of Bed, Bowel and Bladder Control**

****Medical Equipment Includes Wheelchair, Walker, Motorized Scooter, Quad Cane, Canadian Crutches, Catheters, Ventilators, Oxygen, Stair lift, or Home Intravenous Medications.**

STOP! If questions 1 OR 2 are checked "Yes," we cannot offer coverage at this time. **Do not Submit the Application.**

3. In the *past 2 years* have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services for, or taken any medication for any of the following? ☐ YES ☐ NO

- Arthritis with Multiple Joint Replacements or Causing Limitations
- Cancer
- Cardiomyopathy or Congestive Heart Failure
- Chronic Blood Disorders
- Chronic Muscular or Neurological Conditions
- Vascular Disease or other Circulatory Disease
- Diabetes
- Drug/Substance Abuse
- Bowel or Bladder Problems
- Falls, Fractures, or Compression Fractures
- Joint Deformities
- Lung Disorders such as COPD or Emphysema
- Manic–Depression
- Stroke OR TIA OR Amaurosis Fugax- Single Episode

4. **In the *past year*** have you been hospitalized overnight, been advised to have surgery, received rehabilitative services including physical or occupational therapy, OR have you received disability income or worker's compensation? ☐ YES ☐ NO

List ALL Current Medications –Use Extra Paper if Needed. ☐ **No Medications**

Medication	Dosage (x/day)	Reason Taking	#Months On Med

STOP HERE AND READ THESE INSTRUCTIONS

[If YOU are Age 71 or Younger AND purchasing a $100,000 or $200,000 Cash Benefit Account

☛ ***GO TO SECTION VI: Authorization to Obtain Protected Health Information*** ☚ **]**

☛ **ALL [OTHER] APPLICANTS-** ***GO TO SECTION V. Insurability Profile (Continued)*** ☚

V. INSURABILITY PROFILE (Continued) If any question in this section is answered Yes, give full details below.

Producers: Call the Underwriting Hotline for Pre-qualification Review: 1-877-233-5435

During the past 5 Years have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services for, or taken any medication for any condition(s) or symptom(s) of the following (1-8)?

1. Any Heart, Circulatory, Vascular, or Blood problems? ☐YES ☐ NO
Examples (List not all inclusive): Aneurysms, Strokes, TIA, Heart Attack, Angina, Dizziness, Pacemaker, Chest Pain, Irregular Heartbeat, Vascular Headaches, Peripheral Vascular Disease, Carotid Disease, Thrombocytopenia, Anemia and Hypertension

2. Any Bone, Joint, Muscular or Connective Tissue problems? ☐YES ☐ NO
Examples (List not all inclusive): Arthritis, Osteoporosis, Osteopenia, Back Problems, Paget's Disease, Polymyalgia, Rotator Cuff Tear, Bunion Surgery, Spinal Stenosis, Connective Tissue Disease

3. Any Respiratory Problems? ☐YES ☐ NO
Examples (List not all inclusive): Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema, Bronchitis, Sarcoidosis

4. Any Endocrine Problems? ☐YES ☐ NO
Examples (List not all inclusive): Diabetes, Thyroid problem, Hormone Replacement, Pancreatitis, Hyperparathyroidism

5. Any Neurological, Eye or Ear Problems? ☐YES ☐ NO
Examples (List not all inclusive): Bell's Palsy, Blindness, Carpal Tunnel, Cerebral Palsy, Epilepsy, Parkinson's Restless Leg, Seizure Disorder, Tremors, Unsteadiness, Loss of Balance, Falls, Glaucoma, Macular Degeneration

6. Any Mental, Alcohol or Drug Problems? ☐YES ☐ NO
Examples (List not all inclusive): Anxiety, Depression, Alcoholism, Manic Depression, Memory Loss

7. Any Digestive, Bladder, or Kidney Problems? ☐YES ☐ NO
Examples (List not all inclusive): Colitis, Colon Polyps, Gallbladder Disease, GI Bleed, Hiatal Hernia, Loss of Appetite, Nephrectomy, Renal Disease, Prostate Enlargement, Stress Incontinence, Weight Gain, Weight Loss, Dyspepsia

8. Any Cancer? ☐YES ☐ NO
Examples (List not all inclusive): Breast Cancer, Prostate Cancer, Uterine Cancer, Thyroid Cancer, Leukemia, Skin Cancer

9. Have you ***ever*** been turned down for nursing home, home health care, or disability insurance? If "Yes:" ☐YES ☐ NO
Company/Reason: **Date:**

10. In the *past 2* years have you used tobacco products? ☐YES ☐ NO
If "YES," Type: _____Amount/Frequency: _____/_____ *If quit, give date:* _____

Provide Details of Diagnoses including Date of Onset, Tests/Treatments/Follow-up over the last 5 Years for All Conditions.
Please use extra sheet of paper if needed.

Description of Condition/Problem	Date of Onset MM/YYYY	Type of Tests/Treatment/Follow-Up/Medication Changes in last 5 years	# Months Stable (No Change in Treatment)

VI. SIGNATURE AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF DETERMINING INSURABILITY

Physician(s) Name	Physician(s) Street Address, City, State, Zip	Phone #	Date Last Seen
1. Primary Care Physician			
2. Other Physicians (Indicate Specialty)			

PRINT APPLICANT NAME: _____

Applicant Social Security Number: _____

From Me. I agree to permit company representatives to contact me to ascertain my health status to determine if my application is accepted.

From My Health Care Providers. I authorize any physician, medical practitioner, hospital, clinic or other health care provider or health related facility, including but not limited to those listed above, insurance or reinsurance company or employer, having information available as to any diagnosis, treatment and prognosis with respect to any of my physical or mental conditions and/or treatments, to furnish MedAmerica Insurance Company and/or designated business associates acting as insurance support organizations on MedAmerica Insurance Company's behalf any such protected health information, which may include my entire medical record, needed to determine my eligibility for insurance. THIS AUTHORIZATION EXPRESSLY INCLUDES INFORMATION ABOUT DRUGS, ALCOHOLISM, MENTAL ILLNESS AND COMMUNICABLE DISEASES. This authorization does not include psychotherapy notes. Regulations require a separate authorization for psychotherapy notes. We will contact you if we determine that such an authorization is needed.

For 24 Months. I agree that this authorization will be valid for 24 months from the date signed below and that a photocopy shall be as valid as this original. You may revoke this authorization at any time by giving written notice of revocation to the [LTC Privacy Officer, PO Box 41930, Rochester, New York 14604 or LTCPrivacy.Officer@MedAmericaLTC.com]. Revocation will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Your Rights. Although voluntary, this authorization is required to determine your eligibility for enrollment. If you choose not to complete this authorization, we will be unable to determine your eligibility for insurance. By signing this authorization, you acknowledge that if you authorize a person or organization to receive your protected health information that is not a health plan, covered health care provider or health care clearinghouse subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Dated at: City_____**State** _____**Month** _____**Day**_____**Year** _____

☛ **APPLICANT'S SIGNATURE:**_____

VII. SIGNATURES AND AUTHORIZATIONS: To be completed by ALL Applicants.

1. **FRAUD NOTICE:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.

2. **PROTECTION AGAINST UNINTENDED LAPSE:** I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until **31 days after** a premium is due and unpaid. I understand, also, that I have the right not to appoint a lapse designee. Therefore, **I select *one* of the following options:**

   ☐ **I elect NOT to designate** any person to receive such notice.

   ☐ **I designate** the person listed below to be notified by MedAmerica Insurance Company if my premium is not paid:

Name:_____ Phone Number:_____

Address:_____
Street City State Zip

3. **INFLATION PROTECTION OPTION:** I have reviewed the Outline of Coverage and the graph that compare the benefits and premiums of this Policy with and without inflation protection, and

   ☐ **I ACCEPT inflation protection.**
   ☐ **I REJECT inflation protection.**

4. **SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER:** I have reviewed the Outline of Coverage describing the available nonforfeiture benefit rider, and

   ☐ **I ACCEPT the Shortened Benefit Period Non-forfeiture Rider.**
   ☐ **I REJECT the Shortened Benefit Period Non-forfeiture Rider.**

5. **DECLARATION AND APPLICATION CONDITIONS**

To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this application is for consideration and the company will use this application or require, at their expense, that I see a health care professional to determine if my application is accepted. I understand that the premium for the coverage I have applied for is based on medical underwriting. The premium I was quoted includes certain assumptions regarding my health. Therefore, the premium for my policy may be different from the premium I was quoted. My coverage will begin when I am notified of the effective date of coverage, or if selected, my alternate effective date. To receive benefits under this policy, I understand I must satisfy the elimination period and the benefit eligibility requirements as set forth in the policy.

I acknowledge receipt of the Outline of Coverage, Suitability Personal Worksheet (if applicable in my state), Rate and Disclosure Form (if applicable in my state), and appropriate Shopper's Guide.

I understand the Producer or Broker of Record for my Policy, and any managing entities (which may include an affiliate of the Company), may receive compensation, monetary and/or non-monetary, as a result of my purchasing this insurance.

CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

I understand that with this signature I am agreeing with all applicable conditions contained in this Section.

Dated at: City_____ State_____ Month _____ Day_____ Year_____

☛ **APPLICANT SIGNATURE:** _____

VIII. PRODUCER STATEMENT

1. **Has the Applicant purchased any other health insurance policy from you during the past five (5) years?** ***If Yes, provide the following information:***

COMPANY	TYPE OF POLICY	POLICY NUMBER	IN FORCE:
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO

2. **By my signature on this form I certify that:**
   (a) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.
   (b) I have consulted with the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
   (c) I am in compliance with the Long Term Care Insurance requirements in the state of residence of the Applicant as shown on his/her/their Application.
   (d) I have delivered the Outline of Coverage, Suitability Personal Worksheet (where required), and Rate Disclosure Form (where required), and appropriate Shopper's Guide to the Applicant at the first time of solicitation.

_____ _____
Soliciting Producer Name (*Please print)* Writing Number

_____
Agency Name

Phone Number (Best number to reach soliciting producer) : (_____) - _____

SOLICITING PRODUCER SIGNATURE:_____ DATE: _____

3. **Are you SPLITTING the Commission Payment?** ☐ YES ☐ NO

If YES, List all producers receiving compensation, their Writing Number(s), and % splits. The first producer listed **MUST** be the soliciting producer and the producer of record. Case splits must total 100%. (*Only Licensed and Appointed Producers/Brokers may receive compensation.)*

Soliciting Producer Name: _____ Writing#: _____ **%**
Please Print First Name, Last Name

Co-Producer Name: _____ Writing#: _____ **%**
Please Print First Name, Last Name

Co-Producer Name: _____ Writing#: _____ **%**
Please Print First Name, Last Name **TOTAL: 100 %**

4. How was case quoted? ☐ Preferred ☐ Standard **(You are required to Attach a Proposal Quote)**

Amount of Conditional Premium Check (attached): $_____

As per the Conditional Receipt, Modal Premium is Required*

***If EFT, 2 months premium is required; if Payroll Deduction or Employer Paid, no premium is required**

Special Requests, Remarks, and Instructions:

MEDAmerica INSURANCE COMPANY
An Excellus Company *Home Office: Pittsburgh, PA*

[Administrative Offices:]
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

Simplicity[ii]

Long Term Care Insurance
TAX QUALIFIED COVERAGE

EMPLOYER PROGRAM APPLICATION
SPL2-336-AR

❒ **NEW POLICY**
❒ **COVERAGE INCREASE**
Indicate your current policy number here: _____

EP Name: _____
Case Number: _____

I. APPLICANT INFORMATION: 6 Questions to Complete

1. IDENTIFYING INFORMATION

Applicant Name (First, MI, Last)	**Social Security Number**

Legal Residence Street Address (no PO Box - Must Provide Street Address)	**Mailing/Delivery Street Address (if different)**
City State Zip	**City State Zip**

Home Phone ( )	**Work Phone** ( )	**Best Time to Call**: ☐ **AM** ☐ **PM**	**Email:**

Date of Birth: ____/____/____ **MM / DD / YYYY**	**Age (On Date Signed)**	**Sex:** ☐ **Male** ☐ **Female**	**Height:** **Ft. In.**	**Weight:** **Lbs.**

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Single with Care Partner * ☐ Widowed with Care Partner *

* ***If you are Widowed or Single and applying for the Care Partner Premium, the Care Partner Statement must be signed.***

2. ELIGIBILITY STATUS FOR EMPLOYER PROGRAM: (Complete A. OR B.)

A. I am the Eligible of the Employer Program (Check One)

☐ Actively At Work Employee [1] During Open-Enrollment ☐ Actively At Work New Hire Date of Hire: _____
[☐ Actively At Work Employee [1] After Initial Open-Enrollment]
[☐ Eligible Employee but NOT an Actively at Work Employee [1], as defined below]
[☐ Retiree] [☐ Board Member] [Employee Census ID _____]

B. I am related to the Eligible of the Employer Program (Check One)

[☐ Care Partner (Spouse /Domestic Partner)] [☐Parent] [☐Child (adopted & step)] [☐Parent-in-law]
[☐Care Partner of a Child] [☐ Brother/Sister (adopted, step, & in-law)] [☐Grandparent] [☐ Grandparent-in-law]

_____ _____
First, Last Name of Eligible of the Employer Program [Eligible Census ID -SSN, Employee ID or DOB]

[[1]Actively At Work Employee shall mean an employee or Care Partner of an employee, [**aged 18 to 71**,] currently paid by the above employer, employed outside the home by another employer, or self-employed outside the home, and not on Leave Without Pay or an authorized absence due to illness or injury for more than 5 consecutive days over the last 180 days. **The Actively At Work must be regularly scheduled to work not less than 30 hours per week** and be present at their Employer's place of business or an alternate work site as designated by the Employer and be performing the material and substantial duties of their jobs. If the employee works from home, they are considered Actively At Work if they are not hospital confined and not disabled to a degree that they could not have reported for work at the Employer's usual place of business and performed all the material and substantial duties of their occupations not less than 30 hours per week.]

[**APPLICANT that is ACTIVELY AT WORK EMPLOYEE of the Employer Program:** I hereby acknowledge that I am an Actively At Work Employee of the Employer offering this program **as defined above**.

SIGNATURE of APPLICANT that is ACTIVELY AT WORK EMPLOYEE☛ _____]

[APPLICANT that is ACTIVELY AT WORK CARE PARTNER of an Eligible of the Employer Program: I hereby acknowledge that I am an Actively At Work Employee, as defined above, AND that I am the Care Partner of an Eligible Member of the Employer Program. I understand that I may be required to provide proof of my actively at work status. By my signature below, I authorize my Employer to verify my employment status for MedAmerica Insurance Company (the Company) on request. If I am self-employed, I understand additional documentation may be required at the Company's discretion. **Name of Employer/Phone#** _____

SIGNATURE of APPLICANT -ACTIVELY AT WORK CARE PARTNER☛ _____ **]**

OFFICE USE ONLY: App. Rec: _____ App Status: _____ Eff. Date: _____ UW Date: _____ Init: _____

I. APPLICANT INFORMATION (Continued)

3. CARE PARTNER (Spouse/Domestic Partner) INFORMATION

a) Is your Care Partner (Spouse/Domestic Partner) applying for coverage at this time? ☐ YES* ☐ NO **If YES, answer (c)**

b) Does your Care Partner (Spouse /Domestic Partner) have a MedAmerica policy? ☐ YES* ☐ NO **If YES, answer (c)**

c) Care Partner (Spouse /Domestic Partner) name and SS# : _____ _____

Name (First, MI, Last) Social Security Number

* ***Single or Widowed Care Partners must complete the Care Partner Statement.***

4. ALTERNATE EFFECTIVE DATE

☐ **Same as Care Partner (Spouse/Domestic Partner)** ☐**Other:** _____ **Refer to Conditional Receipt**

5. ALTERNATE BILLING ADDRESS: Address that applicant is requesting billing be mailed to IF different than the Applicant Address.

Name (First, MI, Last)	**Phone Number** ( )

Street Address	**City**	**State**	**Zip**

6. BENEFICIARY (optional) A Beneficiary is a person(s) named by You to receive any premiums that may be due in the event of Your death.

Beneficiary Name (First, MI, Last)	**Relationship**	**Phone Number** ( )

Street Address	**City**	**State**	**Zip**

II. INSURANCE HISTORY

1. Are you covered by a state assistance program (Medicaid)?
If YES, as a Medicaid recipient you probably should not apply for this coverage. We recommend ending the application at this point. ☐ **YES** ☐ **NO**

2. Do you currently or have you had in the last 12 months another nursing home (NH), home health care, long term care insurance policy, rider or certificate in force? **If Lapsed, Provide Term Date** ☐ **YES** ☐ **NO**

If YES, please provide the following information. (Please use extra paper if needed)

2a). Company Name	**Address (Street, City, State, Zip)**	**Policy Type:** ☐ NH & Home Care ☐ NH Only ☐ Home Care Only

Still In Force ☐ Yes ☐ No	**Policy Number**	**Daily Benefit Amount**	**Years Coverage**	**Effective Date**	**Term Date**

2b). Company Name	**Address (Street, City, State, Zip)**	**Policy Type:** ☐ NH & Home Care ☐ NH Only ☐ Home Care Only

Still In Force ☐ Yes ☐ No	**Policy Number**	**Daily Benefit Amount**	**Years Coverage**	**Effective Date**	**Term Date**

3. Are you allowing any other nursing home (NH), home health care, long term care insurance policy, rider or certificate to lapse or do you intend to replace any other nursing home, home health care, long term care insurance policy, rider or certificate with this policy? **If Lapsed, Provide Term Date** ☐ **YES** ☐ **NO**

I**f YES, You must sign both Notices Regarding Replacement of Accident and Sickness or Long term Care Insurance Forms. Submit Company Copy with this Application and retain the Applicant Copy.**

Company Name	**Address (Street, City, State, Zip)**	**Policy Type:** ☐ NH & Home Care ☐ NH Only ☐ Home Care Only

Still In Force ☐ Yes ☐ No	**Policy Number**	**Daily Benefit Amount**	**Years Coverage**	**Effective Date**	**Term Date**

III. POLICY BENEFIT SELECTION: COMPREHENSIVE COVERAGE 6 Steps to Complete

STEP 1: CASH BENEFIT ACCOUNT (Choose One)	STEP 2: MONTHLY CASH BENEFIT (Choose One From the SAME Row as Your Cash Benefit Account)			
	MONTHLY CASH BENEFIT	EFB: [2] Increase Facility Benefit to:	MONTHLY CASH BENEFIT	EFB: [2] Increase Facility Benefit to:
☐ $100,000 2 Options: a or b	a. ☐ $1,500	☐ EFB $2,000		
	b. ☐ $3,000 [3]	☐ EFB $4,000		
☐ $200,000 4 Options: a, b, c, or d	a. ☐ $1,500	☐ EFB $2,000	c. ☐ $4,500	☐ EFB $6,000
	b. ☐ $3,000	☐ EFB $4,000	d. ☐ $6,000 [3]	☐ EFB $8,000
☐ $300,000 3 Options: a, b, or c	a. ☐ $3,000	☐ EFB $4,000		
	b. ☐ $4,500	☐ EFB $6,000		
	c. ☐ $6,000	☐ EFB $8,000		
☐ $500,000 2 Options: a or b	a. ☐ $4,500	☐ EFB $6,000		
	b. ☐ $6,000	☐ EFB $8,000		

[2] **EFB- ENHANCED FACILITY BENEFIT (Optional): If Selected Increases Facility Coverage to EFB Amount Indicated**

[3] **Shared Care Rider is Not Available with these Combinations**

STEP 3: ELIMINATION PERIOD Choose One	STEP 4: INFLATION Choose One	STEP 5: PREMIUM PAYMENT OPTIONS Choose One
☐ 30 Days	☐ None	☐ Lifetime
☐ 60 Days	☐ 5% Simple	☐ 10 Pay
☐ 90 Days	☐ 3% Compound: No Max	☐ Paid Up at Age 65 [4]
☐ 180 Days	☐ 5% Compound: No Max	
	☐ 5% Compound 2x Max	[4] Not available after age 55

STEP 6: Riders: Riders are available only at the time of Original Purchase unless otherwise stated.		Check Riders You Are Applying For
Shared Care Rider [5]	*Policies must be identical in benefits and premium payment options.* *Also **not** available with:* • *Restoration of Benefits Rider;* • *Comprehensive Coverage $100,000 Cash Benefit Account and $3,000 Monthly Cash Benefit;* • *Comprehensive Coverage $200,000 Cash Benefit Account and $6,000 Monthly Cash Benefit;*	☐
Shared Waiver Rider [5]	• ***Not** available if Care Partners' age difference is more than 15 years.*	☐
Survivor Benefit Rider [5]	• ***Not** available if Care Partners' age difference is more than 15 years.* • ***Not** available with 10 Pay Premium Payment Option.*	☐
[5] *For all of the above Shared Riders:* • *Both Care Partners Must Purchase the Riders and the Riders must have the Same Effective Date.* • *If one Care Partner is Not Eligible or Does Not Apply, they must apply within 6 months of the Original Care Partner and the Original Care Partner can not be Eligible for Benefits at the time the Rider is requested.*		
[Restoration of Benefits Rider.	• ***Not** Available with Shared Care Rider.*	☐]
Non-forfeiture Riders	**[Return of Premium Rider:** *Available to Applicants **Age 75 and Under**.* • ***Not** available with Full Return of Premium Rider*	☐]
	[Full Return of Premium Rider: *Available to Applicants **Age 65 and Under**.* • ***Not** available with Return of Premium Rider*	☐]
	Shortened Benefit Period Rider	☐

IV. PREMIUM PAYMENT INFORMATION: All Applicants must SELECT ONE method and complete required information.

1. ☐ DIRECT BILL

Select the frequency of your Direct Billing payment

☐ Quarterly

☐ Semi-Annual

☐ Annual

2. ☐ ELECTRONIC FUNDS TRANSFER (EFT)

Select the frequency of your EFT payment.

☐Monthly ☐Quarterly ☐Semi-Annual ☐ Annual

_____

Bank Name

_____ _____

Bank Account Number **Routing Number (9 numbers)**

Requires Minimum of 2 months Conditional Premium. Attach Voided Check if Requesting EFT from Different Bank Account than Conditional Premium Check.

***Sign Authorization Below**

3. ☐ CREDIT CARD

Select the frequency of your Credit Card payment

☐Monthly ☐Quarterly ☐Semi-Annual ☐ Annual

☐ **VISA** ☐ **MASTERCARD**

_____

Credit Card Number

_____

Expiration Date MM/YY

***Sign Authorization Below**

***Authorization for EFT and Credit Card: Required IF Choosing EFT OR Credit Card Payment Method**

I authorize my financial institution or credit card company to automatically make payments to MedAmerica Insurance Company for my insurance. This authorization shall remain in force until I give notification of termination to my financial institution and MedAmerica Insurance Company in writing.

☛_____

Account Holder Signature

☛_____

Joint Account Holder Signature

4. [☐ 100% Employer Paid

(Your Employer is Paying all the Premium for the Benefits Chosen)]

[5. ☐ PAYROLL DEDUCTION (Available only if approved by Affiliation/Employer)

I authorize my Affiliation/Employer to deduct the applicable premium from my salary. I may revoke this authorization at any time by written notice to my Affiliation/Employer and to MedAmerica Insurance Company.

_____

Print Name of Employee/Member (First, Last Name)

☛_____]

Employee/Member Signature

[_____]

[Eligible Census ID -SSN, Employee ID or DOB]
[Required if Employee/Member is NOT the Applicant]

V. INSURABILITY PROFILE-MUST BE COMPLETED BY ALL APPLICANTS: Continue Completing the Insurability Profile Unless You are Directed to STOP- Please read the Stop Instructions Carefully.

[SPEEDApp℠]

INSTRUCTIONS: You must answer each question by **checking YES or NO.**

1. Have you ever received Medical Advice, Consultation, or Treatment for any of the following conditions: ☐ YES ☐ NO

- Alzheimer's Disease, Lewy Body Disease, Dementia, Any Memory Problems, Psychosis, Schizophrenia, Mental Retardation
- Amytrophic Lateral Sclerosis (ALS), Myasthenia Gravis, Multiple Sclerosis, Parkinson's Disease/Parkinsonism
- Post-Polio Syndrome, Demyelinating Disease, Other Neurological Conditions affecting the brain or spinal cord
- Lupus (SLE), Mixed Connective Tissue Disease, Scleroderma, Muscular Dystrophy, Other Muscular Conditions Causing Limits
- Kidney Disease, Polycystic Kidney Disease, Liver Cirrhosis, Hepatitis, Hemachromatosis
- Amputation-Due to Disease, Double Heart Valve Replacement , Organ or Bone Marrow Transplants
- Brain or Spinal Tumors-benign or malignant, Multiple Myeloma
- Peripheral Vascular Disease **and** Smoking, Peripheral Vascular Disease **and** Diabetes, Skin Ulcers **and** Diabetes
- 2 or more Strokes or Transient Ischemic Attacks(TIAs), Single Stroke OR TIA **and** Diabetes
- AIDS- You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS.

2. In the past year have you needed assistance or supervision in performing activities of daily living*, used any Medical Equipment**, or received nursing home care, home health care, assisted living care, or adult day care services? ☐ YES ☐ NO

***Activities of Daily Living Include Walking, Dressing, Eating, Toileting, Taking Medications, Getting In and Out of Bed, Bowel and Bladder Control**

****Medical Equipment Includes Wheelchair, Walker, Motorized Scooter, Quad Cane, Canadian Crutches, Catheters, Ventilators, Oxygen, Stairlift, or Home Intravenous Medications.**

STOP! IF questions 1 OR 2 are "Yes," we cannot offer coverage at this time. Do not Submit the Application.

3. In the *past 2 years* have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services for, or taken any medication for any of the following? ☐ YES ☐ NO

- Arthritis with Multiple Joint Replacements or Causing Limitations
- Cancer
- Cardiomyopathy or Congestive Heart Failure
- Chronic Blood Disorders
- Chronic Muscular or Neurological Conditions
- Vascular Disease or other Circulatory Disease
- Diabetes
- Drug/Substance Abuse
- Bowel or Bladder Problems
- Falls, Fractures, or Compression Fractures
- Joint Deformities
- Lung Disorders such as COPD or Emphysema
- Manic–Depression
- Stroke/TIA/Amaurosis Fugax- Single Episode

4. **In the *past year*** have you been hospitalized overnight, been advised to have surgery, received rehabilitative services including physical or occupational therapy, OR have you received disability income or worker's compensation? ☐ YES ☐ NO

[**STOP! IF You are Applying During Open Enrollment AND You are An Actively at Work Employee of the Group**

☛GO TO SECTION VI: Authorization to Obtain Protected Health Information☛]

V. Insurability Profile (Continued) List ALL Current Medications ☐ No Medications

Medication	Dosage (x/day)	Reason Taking	#Months On Med

[STOP!

IF You are applying During Open Enrollment AND You are an Actively at Work Care Partner of an Employee

OR You are Age 71 or Younger Purchasing a $100,000 or $200,000 Cash Benefit Account

☛GO TO SECTION VI: Authorization to Obtain Protected Health Information☛]

V. INSURABILITY PROFILE (Continued) If any question in this section is answered Yes, give full details below.

Producers: Call the Underwriting Hotline for Pre-qualification Review: 1-877-233-5435

During the past 5 Years have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services for, or taken any medication for any condition(s) or symptom(s) of the following (1-8)?

1. **Any Heart, Circulatory, Vascular, or Blood problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Aneurysms, Strokes, TIA, Heart Attack, Angina, Dizziness, Pacemaker, Chest Pain, Irregular Heartbeat, Vascular Headaches, Peripheral Vascular Disease, Carotid Disease, Thrombocytopenia, Anemia and Hypertension
2. **Any Bone, Joint, Muscular or Connective Tissue problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Arthritis, Osteoporosis, Osteopenia, Back Problems, Paget's Disease, Polymyalgia, Rotator Cuff Tear, Bunion Surgery, Spinal Stenosis, Connective Tissue Disease
3. **Any Respiratory Problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema, Bronchitis, Sarcoidosis
4. **Any Endocrine Problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Diabetes, Thyroid problem, Hormone Replacement, Pancreatitis, Hyperparathyroidism
5. **Any Neurological, Eye or Ear Problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Bell's Palsy, Blindness, Carpal Tunnel, Cerebral Palsy, Epilepsy, Parkinson's Restless Leg, Seizure Disorder, Tremors, Unsteadiness, Loss of Balance, Falls, Glaucoma, Macular Degeneration
6. **Any Mental, Alcohol or Drug Problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Anxiety, Depression, Alcoholism, Manic Depression, Memory Loss
7. **Any Digestive, Bladder, or Kidney Problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Colitis, Colon Polyps, Gallbladder Disease, GI Bleed, Hiatal Hernia, Loss of Appetite, Nephrectomy, Renal Disease, Prostate Enlargement, Stress Incontinence, Weight Gain, Weight Loss, Dyspepsia
8. **Any Cancer?** ☐YES ☐ NO
   Examples (List not all inclusive): Breast Cancer, Prostate Cancer, Uterine Cancer, Thyroid Cancer, Leukemia, Skin Cancer
9. Have you ***ever*** been turned down for nursing home, home health care, or disability insurance? If "Yes:" ☐YES ☐ NO
   Company/Reason:_____ **Date:** _____
10. **In the *past 2* years** have you used tobacco products? ☐YES ☐ NO
    If "YES," Type: _____ Amount/Frequency: _____/_____ *If quit, give date:* _____

Provide Details of Diagnoses including Date of Onset, Tests/Treatments/Follow-up over the last 5 Years for All Conditions.
Please use extra sheet of paper if needed.

Description of Condition/Problem	Date of Onset MM/YYYY	Type of Tests/Treatment/Follow-Up/Medication Changes in last 5 years	# Months Stable (No Change in Treatment)

VI. AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF DETERMINING INSURABILITY AND SIGNATURES

Physician(s) Name	Physician(s) Street Address, City, State, Zip	Phone #	Date Last Seen
1. Primary Care Physician			
2. Other Physicians (Indicate Specialty)			

PRINT APPLICANT NAME: _____

Applicant Social Security Number: _____

From Me. I agree to permit company representatives to contact me to ascertain my health status to determine if my application is accepted.

From My Health Care Providers. I authorize any physician, medical practitioner, hospital, clinic or other health care provider or health related facility, including but not limited to those listed above, insurance or reinsurance company or employer, having information available as to any diagnosis, treatment and prognosis with respect to any of my physical or mental conditions and/or treatments, to furnish MedAmerica Insurance Company and/or designated business associates acting as insurance support organizations on MedAmerica Insurance Company's behalf any such protected health information, which may include my entire medical record, needed to determine my eligibility for insurance. THIS AUTHORIZATION EXPRESSLY INCLUDES INFORMATION ABOUT DRUGS, ALCOHOLISM, MENTAL ILLNESS AND COMMUNICABLE DISEASES. This authorization does not include psychotherapy notes. Regulations require a separate authorization for psychotherapy notes. We will contact you if we determine that such an authorization is needed.

For 24 Months. I agree that this authorization will be valid for 24 months from the date signed below and that a photocopy shall be as valid as this original. You may revoke this authorization at any time by giving written notice of revocation to the [LTC Privacy Officer, PO Box 41930, Rochester, New York 14604 or LTCPrivacy.Officer@MedAmericaLTC.com]. Revocation will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Your Rights. Although voluntary, this authorization is required to determine your eligibility for enrollment. If you choose not to complete this authorization, we will be unable to determine your eligibility for insurance. By signing this authorization, you acknowledge that if you authorize a person or organization to receive your protected health information that is not a health plan, covered health care provider or health care clearinghouse subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Dated at: City_____ **State** _____ **Month**_____ **Day**_____**Year**_____

☛ **APPLICANT'S SIGNATURE:** _____

VII. SIGNATURES AND AUTHORIZATIONS: To be completed by ALL Applicants.

1. **FRAUD NOTICE:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.

2. **PROTECTION AGAINST UNINTENDED LAPSE:** I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until **31 days after** a premium is due and unpaid. I understand, also, that I have the right not to appoint a lapse designee. Therefore, **I select *one* of the following options:**

   ☐ **I elect NOT to designate** any person to receive such notice.

   ☐ **I designate** the person listed below to be notified by MedAmerica Insurance Company if my premium is not paid:

Name:_____ Phone Number:_____

Address:_____
Street City State Zip

3. **INFLATION PROTECTION OPTION:** I have reviewed the Outline of Coverage and the graph that compare the benefits and premiums of this Policy with and without inflation protection, and

   ☐ **I ACCEPT inflation protection.**

   ☐ **I REJECT inflation protection.**

4. **SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER:** I have reviewed the Outline of Coverage describing the available nonforfeiture benefit rider, and

   ☐ **I ACCEPT the Shortened Benefit Period Non-forfeiture Rider.**

   ☐ **I REJECT the Shortened Benefit Period Non-forfeiture Rider.**

5. **DECLARATION AND APPLICATION CONDITIONS**

To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this application is for consideration and the company will use this application or require, at their expense, that I see a health care professional to determine if my application is accepted. I understand that the premium for the coverage I have applied for is based on medical underwriting. The premium I was quoted includes certain assumptions regarding my health. Therefore, the premium for my policy may be different from the premium I was quoted. My coverage will begin when I am notified of the effective date of coverage, or if selected, my alternate effective date. To receive benefits under this policy, I understand I must satisfy the elimination period and the benefit eligibility requirements as set forth in the policy.

I acknowledge receipt of the Outline of Coverage, Suitability Personal Worksheet (if applicable in my state), Rate and Disclosure Form (if applicable in my state), and appropriate Shopper's Guide.

I understand the Producer or Broker of Record for my Policy, and any managing entities (which may include an affiliate of the Company), may receive compensation, monetary and/or non-monetary, as a result of my purchasing this insurance.

CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

I understand that with this signature I am agreeing with all applicable conditions contained in this Section.

Dated at: City _____ **State** _____ **Month** _____ **Day** _____ **Year** _____

☛ **APPLICANT SIGNATURE:** _____

VIII. PRODUCER STATEMENT

1. Has the Applicant purchased any other health insurance policy from you during the past five (5) years? ***If Yes, provide the following information:***

COMPANY	TYPE OF POLICY	POLICY NUMBER	IN FORCE:
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO:

2. By my signature on this form I certify that:

(a) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.
(b) I have consulted with the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
(c) I am in compliance with the Long Term Care Insurance requirements in the state of residence of the Applicant as shown on his/her/their Application.
(d) I have delivered the Outline of Coverage, Suitability Personal Worksheet (where required), and Rate Disclosure Form (where required), and appropriate Shopper's Guide to the Applicant at the first time of solicitation.

_____ _____
Soliciting Producer Name (*Please print)* Writing Number

_____
Agency Name

Phone Number (Best number to reach soliciting producer) : (_____) - _____

SOLICITING PRODUCER SIGNATURE: _____ DATE: _____

3. Are you SPLITTING the Commission Payment? ☐ YES ☐ NO

If YES, List all producers receiving compensation, their Writing Number(s), and % splits. The first producer listed **MUST** be the soliciting producer and the producer of record. Case splits must total 100%. (*Only Licensed and Appointed Producers/Brokers may receive compensation.)*

Soliciting Producer Name: _____ Writing#: _____ : _____ %
Please Print First Name, Last Name

Co-Producer Name: _____ Writing#: _____ : _____%
Please Print First Name, Last Name

Co-Producer Name: _____ Writing# _____ : _____%
Please Print First Name, Last Name **TOTAL: 100 %**

4. Amount of Conditional Premium Check (attached): $ _____
If Conditional Premium is collected, Modal Premium is Required*
***If EFT, 2 months premium is required if Payroll Deduction or Employer Paid, no premium is required.**

Special Requests, Remarks, and Instructions:

MEDAmerica INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

Administrative Offices:
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

Simplicity[ii]

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE
Policy Number SPL2-336-AR-0708
for Individual Sales

Caution: The issuance of this Long Term Care Policy is based upon Your responses to the questions on Your application. A copy of Your application is enclosed. If Your answers are incorrect or untrue, the Company has the right to deny Benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact the Company at the address above.

Notice to Buyer: This Policy may not cover all of the costs associated with LONG TERM CARE incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

1. **POLICY:** This Policy is an individual Policy of insurance.

2. **PURPOSE OF OUTLINE OF COVERAGE:** This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You **READ YOUR POLICY CAREFULLY!**

3. **FEDERAL TAX CONSEQUENCES:** This Policy is intended to be a Qualified Long Term Care insurance contract under section 7702B(b) of the Internal Revenue Code.

4. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED:** If You feel this Policy does not meet Your insurance needs, return it to us or Your producer within 30 days. If You do so, We will return any premium You may have paid. We also will void Your Policy from its effective date.

5. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE:** If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the insurance company. Neither MedAmerica Insurance Company nor its producers represent Medicare, the federal government, or any state government.

   DISCLAIMER: THIS POLICY IS NOT DISABILITY INSURANCE OR ANY OTHER TYPE OF INCOME REPLACEMENT COVERAGE. Benefits under this Policy do not replace income or provide payment in the event of illness or accident resulting in disabilities not meeting the definition of Benefit Eligibility as contained herein.

6. **LONG TERM CARE COVERAGE:** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. These services must be provided in a setting other than an acute care unit of a hospital, such as a nursing facility, in the community, or in the home.

This Policy provides coverage up to the Monthly Cash Benefit as listed on the Schedule of Policy Benefits page of Your Policy. Coverage is subject to Policy limitations and an Elimination Period.

7. BENEFITS AND CONDITIONS FOR ELIGIBILITY:

Benefits Provided By This Policy: This Policy pays You a monthly cash amount if You are Benefit Eligible. The actual amount depends on the Monthly Cash Benefit You have chosen and where You are receiving care. Contingent Nonforfeiture Benefits are also included if You do not purchase an optional Nonforfeiture Benefit. All Benefits count toward fulfillment of Your Cash Benefit Account.

Benefit Eligible: This means You will receive Benefits. To be Benefit Eligible or achieve Benefit Eligibility under this Policy all of the following conditions must be met.

1. We have verified You are Chronically Ill;
2. You have a Plan of Care; and
3. Your Elimination Period has been met. (Does not apply to Benefits that do not require meeting the Elimination Period.)

Chronically Ill means that as the result of an Assessment You have been certified by a Licensed Health Care Practitioner as having a chronic illness or disability that causes You to:

a) Require Substantial Assistance with at least two Activities of Daily Living expected to last at least 90 days; or
b) Have a Severe Cognitive Impairment that requires Substantial Supervision.

We will work with You, Your family and Your physician when We need information about Your condition. This information will be gathered by Us or one of Our representatives. You may contact Us with any questions regarding Our decision.

We will also need a Plan of Care. The Plan of Care is updated as Your needs change. You may use the services of Our Personal Care Advisors. These services are provided at not cost to You.

To continue Benefit Eligibility, We must verify You are Chronically Ill and have an updated Plan of Care at least every 12 months.

Activities of Daily Living

Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated ersonal hygiene (including caring for catheter or colostomy bag).

Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.

Toileting: This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: This means the ability to move into or out of a bed, chair or wheelchair.

Elimination Period: There is a one time Elimination Period. The Elimination Period (Waiting Period) is the number of calendar days You must wait before You will receive Benefits. Your Elimination Period begins the earliest of the date We have verified You are Chronically Ill and have a Plan of Care or the date You contact Us to establish Benefit Eligibility. The Elimination Period will end after the number of days chosen by You and shown in Your Schedule of Policy Benefits has ended. Benefits are not payable during the Elimination Period except where the Policy so states.

Days in an Elimination Period are combined, and do not need to be consecutive. You need to meet Your Policy's Elimination Period only once.

OPTIONAL RIDERS UNDER THIS POLICY

You may elect any of the optional Riders listed. Depending on the Rider You select, You may pay an additional premium.

Shortened Benefit Period Rider – Form # S2-SBPR-AR

We will provide continued coverage equal to premiums You have paid if Your Policy has been in force for three years and lapses.

[Return of Premium Rider (ROPR) and Full Return of Premium Rider (FROPR)

– **Form # S2-ROPR-AR and Form # S2-FROPR-AR**

ROPR: If You die while the Policy is in force, We will refund all premiums paid for Your Policy and any Riders less any Benefits paid or payable.

FROPR: If You die while the Policy is in force, We will refund all premiums paid for Your Policy and any Riders disregarding any Benefits paid or payable.**]**

[Restoration of Benefits Rider – Form # S2-ROBR-AR

This Rider will restore this Policy's Cash Benefit Account to the total that would have applied if no Benefits had been paid under this Policy. This Restoration of Benefits applies whenever a period of 180 consecutive days elapses in which:

1. You are not eligible for or being paid Benefits because You are no longer deemed Chronically Ill; and
2. Your Policy did not lapse and all premiums were paid; and
3. You did not exhaust Your Cash Benefit Account; and
4. Your Policy remained in force.**]**

Survivor Benefit Rider – Form # S2-SVR-AR

You and Your Care Partner must both purchase this Rider. If after 10 years Your Care Partner dies, no further payment of premium is due on Your Policy.

Shared Care Rider – Form # S2-SCR-AR

You and Your Care Partner must both purchase this Rider. This Rider permits Care Partners to share the Benefits under their Policies by first using their own Cash Benefit Account and then, at the option of the other Care Partner, drawing Monthly Cash Benefits from your Care Partner's Cash Benefit Account.

If one Care Partner dies, the surviving Care Partner can assume the deceased Care Partner's remaining Cash Benefit Account at no extra premium. In no case can the use of a portion of a Care Partner's Benefits reduce his or her Cash Benefit Account below a level that would provide that Care Partner less than 24 times his/her Facility Monthly Cash Benefit.

Shared Waiver Rider – Form # S2-SWR-AR

You and Your Care Partner must both purchase this Rider. This Rider provides that when one Care Partner's premiums are waived, premiums will be waived for the other.

Facility Only Rider – Form # S2-FACR-AR

This Rider changes the Benefits under Your Policy by providing coverage only when You are Benefit Eligible and either reside in a Qualified Facility or receive care under a Hospice Care Program.

Community Only Rider – Form # S2-COMMR-AR

This Rider changes the Benefits under Your Policy by providing coverage only when You are Benefit Eligible and either reside in other than a Qualified Facility or receive care under a Hospice Care Program.

Compound Inflation - No Maximum Rider – Form # S2-CMP-AR

This Rider provides for an annual increase in Your Cash Benefit Account and Monthly Cash Benefit. On Your policy anniversary date Your Monthly Cash Benefit will be increased by the percentage shown on Your Schedule of Policy Benefits. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. This increase will continue for as long as Your Policy is in force.

Compound Inflation - 2X Maximum Rider – Form # S2-CMP2X-AR

This Rider provides for an annual increase in both Your Cash Benefit Account and Monthly Cash Benefit. On Your Policy Anniversary Date Your Monthly Cash Benefit will be increased by 5%. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. This increase will continue until Your Monthly Cash Benefit is twice its original amount.

Simple Benefit Increase Rider – Form # S2-SBIR-AR

This Rider provides for an annual increase in both Your Cash Benefit Account and Monthly Cash Benefit. On Your Policy Anniversary Date Your Monthly Cash Benefit will be increased by 5% of its original amount. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. This increase will continue for as long as Your Policy is in force.

8. LIMITATIONS AND EXCLUSIONS:

(a) **Pre-existing conditions:** There are no pre-existing condition limitations in this Policy.

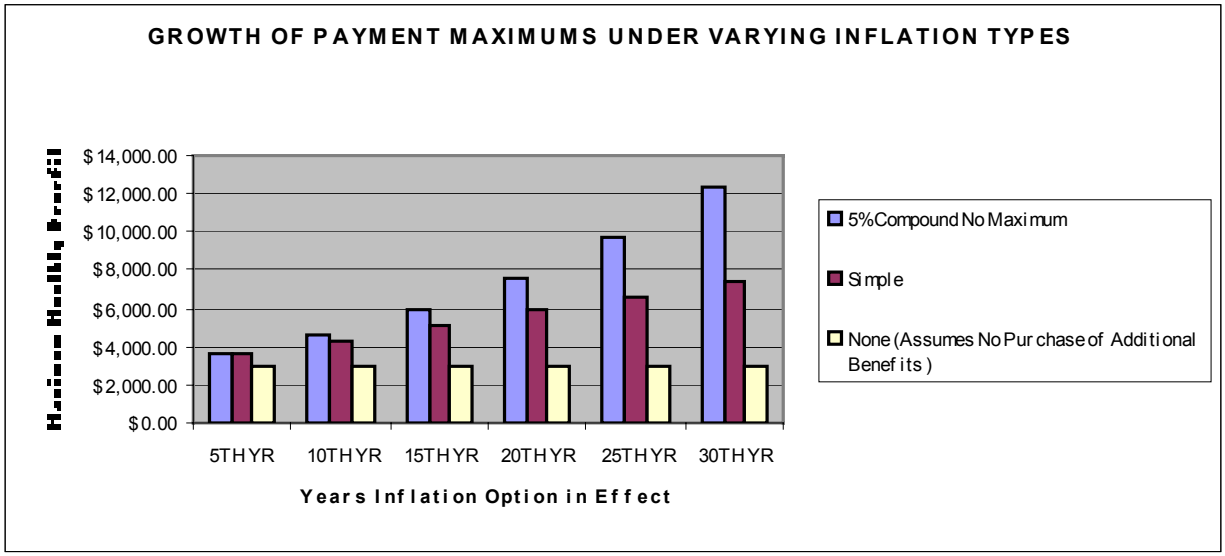
(b) **Exclusions:** Benefits are not payable if Your Chronic Illness is due to War or any act of war, declared or undeclared.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

9. RELATIONSHIP OF COST OF CARE AND BENEFITS:

Because the cost of long term care services will likely increase over time, You should consider whether and how the benefits of this plan might be adjusted. Neither the Cash Benefit Account nor the Monthly Cash Benefit will increase over time if You do not purchase inflation protection.

The following is a hypothetical comparison of the levels of a Policy that increases Monthly Cash Benefits over a period of coverage with a Policy that does not increase Monthly Cash Benefits. The comparison shows the effect on Benefits at five (5) year intervals over thirty years for a client purchasing a $3000 Monthly Cash Benefit with a 5% index percentage.



Compound – No Maximum: If You purchase Compound – No Maximum indexing, both Your Cash Benefit Account and Monthly Cash Benefit will increase on the anniversary of the effective date of the Policy. Your Monthly Cash Benefit will be increased by the percentage shown on Your Schedule of Policy Benefits. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. This increase will continue for as long as Your Policy is in force. Inflation increases will continue without regard to health status or age.

Compound – 2X Maximum: If You purchase Compound – 2X Maximum indexing, both Your Cash Benefit Account and Monthly Cash Benefit will increase on the anniversary of the effective date of the Policy. Your Monthly Cash Benefit will be increased by 5%. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. This increase will continue until Your Monthly Cash Benefit is twice its original amount. Inflation increases will continue up to the two times maximum without regard to health status or age.

Simple: If You purchase simple indexing, Your Cash Benefit Account and Monthly Cash Benefit will increase on every anniversary of the effective date of the Policy. Your Monthly Cash Benefit will be increased by 5% of its original amount. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. Inflation increases will continue without regard to health status or age.

None: If You purchase no indexing, Your Cash Benefit Account and Monthly Cash Benefit will not increase over time.

10. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED:**

(a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means that You have the right, subject to the terms of Your Policy, to continue Your Policy as long as You pay Your premiums on time. MedAmerica Insurance Company cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY CHANGE THE PREMIUM YOU PAY. Where applicable, premium increases must be approved by the State Department of Insurance.

(b) **WAIVER OF PREMIUM:** Your premium payments will be waived on a monthly basis starting the day after the date Your Elimination Period is satisfied. The Waiver of Premium will end on the date You are no longer Benefit Eligible.

(c) **TERMS UNDER WHICH PREMIUMS MAY BE CHANGED:** We reserve the right to increase Your premium as of the premium due date; however, any changes in the premium rates must apply to all similar policies issued in Your state on this Policy form. This means We cannot single You out for an increase because of any change in Your age or health. However, Your rates may go up based on the experience of all policyholders with a Policy similar to Yours.

11. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS:** This Policy provides coverage if You are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses that result in a cognitive impairment.

12. **PREMIUM:**

(a) The total annual premium quoted for Your Policy is shown below. The total premium amount of Your issued Policy is listed on the Premium Information page of Your Schedule of Policy Benefits and may vary from the amount that is identified below due to medical underwriting.
(Producer: Please use the space below to indicate the premium quoted.)

Basic Benefits Annual Premium (Check one)

a) ☐ Comprehensive Coverage
b) ☐ Facility Only
c) ☐ Community Only

$ _____

Optional Riders Modal Premium

Inflation Rider	**$** _____
Survivor Benefit Rider	**$** _____
Shared Waiver Rider	**$** _____
Shared Care Rider	**$** _____
Return of Premium Rider	**$** _____
Full Return of Premium Rider	**$** _____
Restoration of Benefits Rider	**$** _____
Shortened Benefit Period Rider	**$** _____

Total Modal Premium for Optional Riders $ _____
Less any /Affiliation/ Employer Program/ Discounts

Your Total Modal Premium will be: $ _____ on a _____basis*.
The Annualized Modal Premium for this policy is: _____

* You may elect to pay Your premium on other than an annual basis. Please note that payment schedules of less than annual will result in a higher premium amount paid per year.

13. **ADDITIONAL FEATURES:**

(a) Medical underwriting of Your application is used to determine Your eligibility for long term care insurance. It may also be used to determine Your correct Rate Group classification, if applicable.

(b) Benefits may be available after termination if You are receiving Benefits covered under the Policy. See the "Extension of Benefits" section of Your Policy for specific requirements.

(c) If Your Policy terminates because of non-payment, You may apply for reinstatement of the Policy.

(d) No prior hospitalization is required before You can receive coverage under this Policy.

14. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE.

CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

15. **SENIOR COUNSELING PROGRAMS:** Please refer to *A Shopper's Guide To Long Term Care Insurance* contained in Your enrollment material for the telephone number of the Senior Counseling Program in Your state.

17. **LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM**

1. **Premium Rate:** Your premium rate that is applicable to You and that will be in effect until a request is made and filed with Your State Department of Insurance for an increase is shown on Your schedule page in Your policy.

2. The premium for this Policy will be shown on the schedule page of Your policy.

3. **Rate Schedule Adjustments:** If Your rates are changed, the new rates will become effective on the next billing date. The new rates will remain in effect until another request is made and filed with Your State Department of Insurance. You have the right to receive a revised schedule page if the premium rate is changed.

   We have sold long term care insurance since 1987 and have sold this policy since [2007]. We have never raised rates for any long term care policy sold in this state or any other state.

4. **Potential Rate Revision: This policy is Guaranteed Renewable.** This means that the rates for this coverage may be increased in the future. Your rates CANNOT be increased due to Your age or declining health, but Your rates may go up based on the experience of all insureds with a policy similar to Yours. If You receive a premium rate increase in the future, You will be notified of the new premium amount and You will be able to exercise at least one of the following options:

   (a) Pay the increased premium and continue Your coverage in force as is.
   (b) Reduce Your coverage benefits to a level such that Your premiums will not increase.
   (c) Exercise Your long term care nonforfeiture option (Shortened Benefit Period Rider), if purchased. This option is available for purchase for an additional premium.
   (d) Exercise Your contingent nonforfeiture rights - See No. 3. This option is available if You do not purchase a long term care nonforfeiture option mentioned in (c) above.

5. Contingent Nonforfeiture Rights

A. Contingent Nonforfeiture Benefit Option:

(a) If the premium rate for Your policy goes up in the future and You do not buy a long term care nonforfeiture option, You may be eligible for contingent nonforfeiture. Here's how to tell if You are eligible:

You will keep some long term care insurance coverage, if:

(1) Your premium after the increase exceeds Your original premium by the percentage shown, or more, in the table (provided on the next page/below); and

(2) You do not pay Your premium within 120 days of the increase causing Your policy to lapse.

(b) Your Cash Benefit Account under this Rider will be the greater of:
(1) The sum of all premiums paid for Your coverage and any attached Riders under this Policy less benefits paid; or
(2) The Facility Monthly Cash Benefit (Community Monthly Cash Benefit if You have purchased the Community Only Rider) in effect on the date Your coverage under this Policy lapses.

(c) Your Monthly Cash Benefit is payable up to Your Cash Benefit Account under this Rider.

(d) The Cash Benefit Account under this Rider can never be greater than the Cash Benefit Account under Your Policy at the time You elected to use Your contingent nonforfeiture rights.

(e) Except for this reduced Cash Benefit Account, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

(f) Should You choose this Contingent Nonforfeiture option, Your policy, with this reduced Cash Benefit Account, will be considered "paid-up" with no further premiums due. Monthly Cash Benefits from Your Cash Benefit Account will be paid at the level current when the policy was lapsed.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for ten years, so You have paid a total of $10,000 in premium.
- In the eleventh year, You receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and You decide to not pay any more premiums causing Your policy to lapse.
- Your “paid-up” policy benefits are $10,000, provided You have at least $10,000 of benefits remaining under Your policy.

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Nonforfeiture Table

Percentage increase is cumulative from date of original issue.

It does NOT represent a one-time increase.

Issue Age	Substantial Percent Over Initial Premium	Issue Age	Substantial Percent Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

B. Reduced "Paid Up" Contingent Nonforfeiture Benefit Option:

In addition to the Contingent Nonforfeiture Benefits Option (A) described above, the following Reduced "Paid-up" Contingent Nonforfeiture Benefit is an option if You have chosen the 10 year or Paid Up at Age 65 payment option, even if You selected the Shortened Benefit Period option when You purchased Your Policy. You are eligible for the reduced "paid up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65 – 80	30%
Over 80	10%

2. You stop paying premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

   If You exercise this option your coverage will be converted to reduced “paid-up” status. That means there will be no additional premiums required. Your benefits will change in the following ways:

   a. The limited pay Contingent Benefit can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
   b. The monthly benefit amounts you purchased will be adjusted by the same ratio.

   If both the Contingent Nonforfeiture Benefit (A) and the Reduced "Paid up" Contingent Nonforfeiture Benefit (B) are triggered by the same rate increase, you can choose either of the two options.

Example:

You bought the policy at age 65 with an annual premium payable for 10 years.

In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.

Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

MEDAmerica
INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

Administrative Office:
165 Court Street
Rochester, NY 14647

Product Filing/Compliance Division
Tel: (800) 544-0327 x 6522
Fax: (585) 238-3642
E-Mail Address: mary.lou.lawson@Medamericaltc.com

June 26, 2008

Julie Benafield Bowman, Commissioner
Arkansas Department of Insurance
1200 West 3rd. Street
Little Rock, Arkansas 72201-1904

RE: **MedAmerica Insurance Company** **NAIC #:** 69515 00
Form Filing –Tax Qualified Long-Term Care Insurance **FEIN #:** 34-0977231
Form #: SPL2-336-AR-0708, et al.

Dear Commissioner Bowman:

In response to Arkansas' mandate implementing the 2006 version of the NAIC Long Term Care Insurance Model Regulation, the enclosed form filing is submitted for your review. This policy was originally approved on February 28, 2007 under Form No. SPL2-336-AR.

The following revisions have been made:

- **QUALIFIED FACILITIES** definition on Page 6 of the policy has been revised to include in lieu of licensure, certification or registration.

- The **RIGHT TO REDUCE COVERAGE AND LOWER PREMIUM** provision has been added at the end of **Part 4: Premium** section of the Policy on Page 13.

- The **CONTINGENT NONFORFEITURE BENEFIT** provision on Page 16 in the Policy has been revised to include the text for fixed or limited premium payment options.

- Section No. 17 **LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM** (Appendix F) on Page 8 in the Outline of Coverage has been revised to include the new required language for fixed or limited premium payment options.**

- The form entitled, **THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG TERM CARE INSURANCE** (Appendix C) has been revised to comply. The last bullet point **FACILITIES** has been added to the end of the form.**

Form numbers have been modified slightly with the addition of "-0708" to reflect revisions.

**Please note that, pursuant to Arkansas' mandate, Appendixes C and F have been revised for use on January 1, 2009. However, we are requesting Department approval to implement these forms upon approval of NAIC Model changes.

I have also attached copies of previously approved applications, S2-345-AR and S2-346-AR, to reflect the change in form numbers to S2-345-AR-0708 and S2-346-AR-0708, respectively.

The following are enclosed:

- Redlined copies of revised pages;
- Copy of revised forms;
- Forms List with revised form numbers;
- Appendix C (Partnership) Issuer Certification Form.

Please also take note that SPL2-336-AR-0708 is being submitted for use with Arkansas' partnership program.

Thank you for your assistance. Please feel free to contact me with any questions.

Very truly yours,

Mary Lou Lawson
Contracts Management Analyst

APPENDIX C
ISSUER CERTIFICATION FORM
(relating to Qualified State Long-Term Care Insurance Partnership)

In order to provide the Insurance Commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requires information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

MedAmerica Insurance Company
165 Court Street
Rochester, New York 14647

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

Mary Lou Lawson, Contracts Analyst
MedAmerica Insurance Company, 165 Court Street, Rochester, NY 14647
Phone: 800-544-0327, Ext. 6522
E-Mail: mary.lou.lawson@medamericaltc.com

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form (expand the space below as required):

SPL2-336-AR-0708

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

II. CERTIFICATIONS

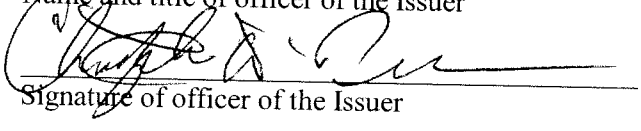
A. I hereby certify that the policy forms listed above are in compliance with Rule 13 and Rule 94 and all other Arkansas statutes and rules regarding long-term care insurance.

B. I hereby certify to the best of my knowledge and belief that all producers who sell, solicit or negotiate long-term care insurance products on {insert issuer name's} behalf have received the training required for Partnership policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care coverage.

C. I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

June 26, 2008
Date

Christopher D. Perna, President
Name and title of officer of the Issuer



Signature of officer of the Issuer

FORMS LIST

MedAmerica Insurance Company

Simplicity^{ii}

Long-Term Care Insurance Policy (Tax-Qualified)

Policy Form # SPL2-336-AR-0708 et al.

Long-Term Care Insurance Policy	SPL2-336-AR-0708
Policy Schedule Page (Located within the Policy)	SPL2-238-AR-0708
Outline of Coverage	S2-151-AR-0708
Application - Individual and Affiliation	S2-345-AR-0708
Application - Employer Program	S2-346-AR-0708
Things You Should Know	202 rev

MEDAmerica INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

Administrative Offices:
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

Simplicity$^{ii}_{SM}$

Thank You for selecting MedAmerica Insurance Company as Your long term care insurer. We are pleased to provide You with this Policy. Your coverage, if the first premium is paid, as stated herein, begins at 12:01 a.m. Standard time at Your home on the Effective Date of this Policy. It ends on 12:01 a.m. Standard time at Your home on the termination date of this Policy.

This Policy is intended to be a federally tax-qualified long term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Us.

DISCLAIMER: THIS POLICY IS NOT DISABILITY INSURANCE OR ANY OTHER TYPE OF INCOME REPLACEMENT COVERAGE. Benefits under this Policy do not replace income or provide payment in the event of illness or accident resulting in disabilities not meeting the definition of Benefit Eligibility as contained herein.

SUBROGATION: If You become eligible for Benefits under this Policy as the result of injury or illness for which another party may be responsible, and We pay You Benefits as the result of that injury or illness, We reserve the right to pursue recovery from such third party, whether by judgment, settlement or otherwise, to the extent of the total amount of Benefits paid to You under this Policy, less reasonable and necessary expenditures, including attorneys' fees, incurred in effecting such recovery. Our right to proceed against the third party is independent of any right of action You may have.

Failure To Cooperate: If You fail to cooperate with Us in proceeding against the party responsible for Your illness or injury to recover the Benefits We have paid, We will be entitled to be reimbursed for said Benefits from a settlement or judgement You receive from the responsible party.

GUARANTEED RENEWABLE/PREMIUM INCREASES: This Policy will continue for Your lifetime as long as You do not exhaust the Cash Benefit Account and You pay the premiums within the allowable time. We cannot change the provisions of this Policy without Your consent. We can change Your premium with 45 days written notice, but only if We change the premiums for all similar Policies issued in Your state on this Policy form. You cannot be singled out for any increase because of a change in Your age or health. NOTE: With the exception of the statement that We cannot change the provisions of this Policy without Your consent, the above paragraph does not apply to Policies on which premiums are no longer payable.

IMPORTANT 30-DAY REVIEW: If You feel this Policy does not meet Your needs, You may return it to Your producer or Us within 30 days. If You do so: (1) We will return the premium You paid; and (2) We will not provide any Benefits under this Policy.

CAUTION: The issuance of this long term care Policy is based upon Your responses to the questions on Your application. A copy of Your application is enclosed. If Your answers are incorrect or untrue, We have the right to deny Benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at the above mailing address.

You may reach the Arkansas Insurance Department at the following address: Arkansas Insurance Department, Consumer Services Division, 1200 West Third Street, Little Rock, AR 72201-1904 or call [1-501-371-2640 or 1-800-852-5494].

This Policy is signed on Our behalf by Our President.

[ ]
[Christopher D. Perna]
[President]

SCHEDULE OF POLICY BENEFITS

Simplicity[ii]

POLICY NUMBER: SPL2-336-AR-0708

BILLING ACCOUNT #:

ORIGINAL POLICY EFFECTIVE DATE: MM/DD/YY

[POLICY CHANGE EFFECTIVE DATE: MM/DD/YY]

POLICYHOLDER ISSUE AGE: [(18-85)]

PAYMENT MODE:

INSURED NAME: XXXXXXXXXX X XXXXXXXXXXXXXX XXX

ADDRESS: Line 1

Line 2

City, State, ZIP Code

BASE BENEFITS AND PREMIUM INFORMATION

ELIMINATION PERIOD:	[30]; [60]; [90]; [180] Days	
CASH BENEFIT ACCOUNT:	[$9,999,999]	
COMMUNITY MONTHLY CASH BENEFIT:	[$99,999] Per Month	
FACILITY MONTHLY CASH BENEFIT:	[$99,999] Per Month	
BASIC BENEFITS MODAL PREMIUM: [Comprehensive Coverage]; [Community Only]; [Facility Only]		[$ 99,999.99]
PREMIUM PAYMENT OPTION: **[X Lifetime:** Premiums are payable as long as Your Policy is in force.] **[X 10 Pay:** Premiums are payable until the 10th Policy Anniversary Date.] **[X Paid Up At Age 65:** Premiums are payable until the first Policy Anniversary Date on or after Your 65th birthday.]		
OPTIONAL RIDERS MODAL PREMIUM:		[$ 99,999.99]
[No Inflation, Benefits Remain Level]; [Simple Benefit Increase Rider]; [5% Compound Inflation Rider – 2X Maximum Rider]; [[3%], [5%] Compound Inflation– No Maximum Rider]	[$ 9,999.99]	
[Survivor Benefit Rider]	[$ 9,999.99]	
[Shared Waiver Rider]	[$ 9,999.99]	
[Shared Care Rider]	[$ 9,999.99]	
[Shortened Benefit Period Rider]	[$ 9,999.99]	
[Return of Premium Rider]	[$ 9,999.99]	
[Full Return of Premium Rider]	[$ 9,999.99]	
[Restoration of Benefits Rider]	[$ 9,999.99]	
Discounts Applied: [Affiliation]; [Employer Program]		**[$ 99,999.99]**
Total Modal Premium Including Optional Riders and Discounts		**[$ 99,999.99]**
Total Annualized Premium Including Optional Riders and Discounts		**[$ 99,999.99]**

PERSONAL CARE ADVISOR

This is a health care professional chosen by Us whose profession and training includes experience or expertise in managing and arranging for long term care services. These services are optional and are provided at no cost to You. Where required, he or she must be licensed and acting within the scope of that license.

PLAN OF CARE

This is a written, individualized plan for care and support services for You that:

1. Has been prescribed by a Licensed Health Care Practitioner; and
2. Has been developed as a result of an Assessment and incorporates any information provided by Your personal physician; and
3. Fairly, accurately and appropriately addresses Your long term care and support service needs; and
4. Specifies the type, frequency and duration of all services required to meet those needs and the providers appropriate to furnish those services.

A Plan of Care is completed at the same time the Assessment is performed.

POLICY

This is a legal agreement between You and Us. It includes this document, Your application, and any attached riders or endorsements.

POLICY ANNIVERSARY DATE

This is the date each year that coincides with the date this Policy went into effect. The first Policy Anniversary Date will be one year from the date the Policy went into effect.

QUALIFIED FACILITY

A Qualified Facility is a state or federally regulated, licensed, accredited or certified facility as defined by Arkansas law that meets all of the following criteria. If a facility is not state or federally regulated, licensed, accredited or certified, it must meet ~~that meets~~ all of the following criteria to be considered a Qualified Facility:

- Provides accommodations to 3 or more unrelated individuals and supervision and personal care services for at least 3 of these individuals; and
- Provides 24-hour-a-day care and services; and
- Has a trained, awake, and ready-to-respond employee on duty in the facility at all times to provide necessary care; and
- Provides 2 meals a day and accommodates special dietary needs; and
- Conducts an assessment of the resident on admission that includes a history and physical by a physician, nurse practitioner, or physician assistant in the last 60 days, the resident's ability to perform both instrumental activities of daily living and activities of daily living, safety evaluation, risk of fall assessment, cognitive assessment, and the resident's ability to manage medication administration; and
- Develops a Plan of Care or service plan for each resident that is customized to the resident and includes both the services provided by or contracted by the residence and identifies services that will be provided by outside agencies directly contracted with the insured including the scope of services, frequency of services and monitoring of services delivered; and
- Reviews the service plan at least every six months or as the resident's needs change.

UNEARNED PREMIUM

When We are notified of Your death or the cancellation of this Policy, We will refund any premium paid for the period beyond such notification.

All premiums paid for the period beyond Your death will be refunded.

- Your premiums will be refunded to Your Beneficiary. In the absence of a named Beneficiary, we will refund unearned premium to Your estate.

In the event of the cancellation of this Policy, premiums paid for the period beyond such cancellation will be refunded to You.

The above does not apply if premiums are no longer payable.

RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS

You may, at any time, ask for a decrease in Your coverage. Your request for a decrease in coverage must be made in writing and Your reduced premium will be based on Your age at the time Your original Policy was issued.

We will provide written notice to You, during Your Grace Period, of Your option to reduce coverage to lower Your premium.

PART 6: CONTINGENT NON-FORFEITURE PROVISIONS*

If You have NOT selected the Shortened Benefit Period Option, the following Contingent Non-Forfeiture provisions apply. These provisions change the coverage to provide options in the event this Policy ends due to non-payment of premium after a Substantial Premium Increase.

A Substantial Premium Increase is one that results in a cumulative increase to the annual premium that is equal to or exceeds a certain percentage of the original premium. It does not include premium increases that result from a voluntary purchase of additional coverage. The limits of cumulative increase as a percentage of the annual premium are based on Your age as of the Policy Effective Date shown in Your Schedule of Policy Benefits. The following table shows the cumulative increase that will trigger the Contingent Non-Forfeiture Provision.

*This section shall apply only where premiums are payable. Rights under Contingent Non-Forfeiture Provisions are not available where current and future premiums are neither due nor owing.

SUBSTANTIAL PREMIUM INCREASE TABLE

POLICY ISSUE AGE	PERCENT OF INCREASE	POLICY ISSUE AGE	PERCENT OF INCREASE
Less than 30	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

A. Contingent Nonforfeiture Benefit Option~~Contingency Options~~: You will be notified of any Substantial Premium Increase 45 days prior to the change of Your premium. The notice will include the amount of the premium, its due date, and the following contingency options in the event of lapse.

1. Alternative Benefit options at a lower premium
2. A lesser Cash Benefit Account with no further premium required. You will have 120 days following the premium due date to elect this option. Under this option, the same Monthly Cash Benefit amounts in effect at the time of lapse will be payable, but the Cash Benefit Account will be equal to the greater of items a) or b) below.
    a) The total amount of premiums paid for Your Policy
    b) Your Monthly Cash Benefit

The total of all Benefits paid under Your Policy will not exceed the Cash Benefit Account that would have been payable if Your Policy did not lapse.

Option 2 will automatically take effect if all of the following apply.

1. Your Policy lapses within 120 days of the premium due date for the Substantially Increased Premium; and
2. You have not made an election.

B. Reduced "Paid Up" Contingent Nonforfeiture Benefit Option: In addition to the Contingent Nonforfeiture Benefits Option (A) described above, the following Reduced "Paid-up" Contingent Nonforfeiture Benefit is an option if You have chosen the 10 year or Paid Up at Age 65 payment option, even if You selected the Shortened Benefit Period option when You purchased Your Policy. You are eligible for the reduced "paid up" contingent nonforfeiture benefit without the requirements of additional underwriting when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65 – 80	30%
Over 80	10%

2. You stop paying premiums within 120 days of when the premium increase took effect; **AND**

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If You exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The limited pay Contingent Benefit can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
b. The monthly benefit amounts you purchased will be adjusted by the same ratio.

If both the Contingent Nonforfeiture Benefit (A) and the Reduced "Paid up" Contingent Nonforfeiture Benefit (B) are triggered by the same rate increase, you can choose either of the two options. If You have not made an election, the Reduced "Paid Up" option (B) will take effect if sufficient premium has been paid to make it available.

MEDAmerica INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

Administrative Offices:
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

Simplicity[ii]

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE
Policy Number SPL2-336-AR-0708
for Individual Sales

Caution: The issuance of this Long Term Care Policy is based upon Your responses to the questions on Your application. A copy of Your application is enclosed. If Your answers are incorrect or untrue, the Company has the right to deny Benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact the Company at the address above.

Notice to Buyer: This Policy may not cover all of the costs associated with LONG TERM CARE incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

1. **POLICY:** This Policy is an individual Policy of insurance.

2. **PURPOSE OF OUTLINE OF COVERAGE:** This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You **READ YOUR POLICY CAREFULLY!**

3. **FEDERAL TAX CONSEQUENCES:** This Policy is intended to be a Qualified Long Term Care insurance contract under section 7702B(b) of the Internal Revenue Code.

4. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED:** If You feel this Policy does not meet Your insurance needs, return it to us or Your producer within 30 days. If You do so, We will return any premium You may have paid. We also will void Your Policy from its effective date.

5. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE:** If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the insurance company. Neither MedAmerica Insurance Company nor its producers represent Medicare, the federal government, or any state government.

   DISCLAIMER: THIS POLICY IS NOT DISABILITY INSURANCE OR ANY OTHER TYPE OF INCOME REPLACEMENT COVERAGE. Benefits under this Policy do not replace income or provide payment in the event of illness or accident resulting in disabilities not meeting the definition of Benefit Eligibility as contained herein.

6. **LONG TERM CARE COVERAGE:** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. These services must be provided in a setting other than an acute care unit of a hospital, such as a nursing facility, in the community, or in the home.

5. Contingent Nonforfeiture Rights

A. Contingent Nonforfeiture Benefit Option:

(a) If the premium rate for Your policy goes up in the future and You do not buy a long term care nonforfeiture option, -You may be eligible for contingent nonforfeiture. Here's how to tell if You are eligible:

You will keep some long term care insurance coverage, if:

(1) Your premium after the increase exceeds Your original premium by the percentage shown, or more, in the table (provided on the next page/below); and

(2) You do not pay Your premium within 120 days of the increase causing Your policy to lapse.

(b) Your Cash Benefit Account under this Rider will be the greater of:
(1) The sum of all premiums paid for Your coverage and any attached Riders under this Policy less benefits paid; or
(2) The Facility Monthly Cash Benefit (Community Monthly Cash Benefit if You have purchased the Community Only Rider) in effect on the date Your coverage under this Policy lapses.

(c) Your Monthly Cash Benefit is payable up to Your Cash Benefit Account under this Rider.

(d) The Cash Benefit Account under this Rider can never be greater than the Cash Benefit Account under Your Policy at the time You elected to use Your contingent nonforfeiture rights.

(e) Except for this reduced Cash Benefit Account, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

(f) Should You choose this Contingent Nonforfeiture option, Your policy, with this reduced Cash Benefit Account, will be considered "paid-up" with no further premiums due. Monthly Cash Benefits from Your Cash Benefit Account will be paid at the level current when the policy was lapsed.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for ten years, so You have paid a total of $10,000 in premium.
- In the eleventh year, You receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and You decide to not pay any more premiums causing Your policy to lapse.
- Your “paid-up” policy benefits are $10,000, provided You have at least $10,000 of benefits remaining under Your policy.

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Nonforfeiture Table

Percentage increase is cumulative from date of original issue.

It does NOT represent a one-time increase.

Issue Age	Substantial Percent Over Initial Premium	Issue Age	Substantial Percent Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
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50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

B. Reduced "Paid Up" Contingent Nonforfeiture Benefit Option:

In addition to the Contingent Nonforfeiture Benefits Option (A) described above, the following Reduced "Paid-up" Contingent Nonforfeiture Benefit is an option if You have chosen the 10 year or Paid Up at Age 65 payment option, even if You selected the Shortened Benefit Period option when You purchased Your Policy. You are eligible for the reduced "paid up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65 – 80	30%
Over 80	10%

2. You stop paying premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

   If You exercise this option your coverage will be converted to reduced “paid-up” status. That means there will be no additional premiums required. Your benefits will change in the following ways:

   a. The limited pay Contingent Benefit can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
   b. The monthly benefit amounts you purchased will be adjusted by the same ratio.

   If both the Contingent Nonforfeiture Benefit (A) and the Reduced "Paid up" Contingent Nonforfeiture Benefit (B) are triggered by the same rate increase, you can choose either of the two options.

Example:

You bought the policy at age 65 with an annual premium payable for 10 years.

In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.

Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

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Things You Should Know Before You Buy Long Term Care Insurance

Long-Term Care Insurance

- A long term care insurance policy may pay most of the costs for your care
- in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long term care if you have very little income and few assets. You should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local County Department of Social Services.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of the appropriate Shopper's Guide regarding Long Term Care Insurance approved by Your States Commissioner of Insurance. Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.